Project Title: Colorado Comprehensive Health Access Modernization Program **Applicant Entity:** Colorado Department of Health Care Policy and Financing

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The Department is requesting funding from HRSA, State Health Access Program (SHAP) for seven comprehensive and interrelated projects totaling \$42,773,029 over five years that we are describing as Colorado's Comprehensive Health Access Modernization Program (CO-CHAMP). CO-CHAMP reflects our responsibility as leaders to "champion" policies that will lead to greater access to health care, increase positive health outcomes and reduce cost-shifting. Modernization includes making investments in infrastructure and technology but also includes implementing new strategies around benefit design and cost-sharing. Coverage expansions to over 150,000 Coloradans under HB 09-1293 make it essential to ensure that our current systems work as well as possible to support the increased caseload, making the health care delivery system and access to programs more outcomes-focused and client-centered. The CO-CHAMP projects are: Maximizing Outreach, Retention and Enrollment (MORE) - design, develop, and implement an outreach plan for the expansion populations; *Eligibility Modernization:* Streamlining the Application Process - streamline the application process by replacing paper documentation with electronic data where possible; develop web-based services for clients; and create interfaces to other State and Federal systems to ease data exchange for the expansions populations making it easier for clients to apply for public health insurance programs; Childless Adults and Buy-in for Individuals with Disabilities Implementation - develop potential program designs, including models for premium structures, and cost-sharing provisions for the childless adults and buy-in for individuals with disabilities expansion populations; Premium Assistance Program - expand the CHP+ at Work program statewide to expand coverage to newly CHP+ eligible children who have access to employer-sponsored insurance; *Health Access Pueblo Community* Share Expansion - design, develop and implement an outreach and marketing plan to new businesses on Pueblo County's community-share program known as Health Access Program (HAP) to expand coverage to the working uninsured; San Luis Valley Three-Share Community Start-Up - replicate Pueblo County's HAP and create health care coverage for the working uninsured for San Luis Valley Health Access Program by using SHAP funding to initially support the "community share;" Weld County Evidence-Based Benefit Design Pilot - create an innovate benefit design tool can be implemented easily and administered efficiently for carriers for the purpose of developing new insurance products targeted at previously uninsured populations. An impact evaluation of CO-CHAMP, utilizing client surveys as well as Colorado Benefits Management System (State program eligibility determination data) and Medicaid Management Information System (State health care claims and utilization data) will help us determine the extent to which these projects led to successful enrollment of the 150,000 newly eligible Coloradans, if they accessed services once enrolled, and if this led to improved health and quality of life outcomes under Healthy People 2010 goals.

HRSA SHAP GRANT APPLICATION NARRATIVE - CO-CHAMP PROJECT of HCPF

INTRODUCTION: GOALS AND OBJECTIVES

Prologue: Dateline: June 2, 2009, Denver, CO. Governor Bill Ritter signed into law six bills aimed at helping middle-class Coloradans navigate a sinking economy. At a "Help Fair" near the bill-signing, people milled around tables staffed to aid people with foreclosure, energy, health care and food stamp questions. A young man approached our table and shared the fact he didn't have health insurance because his employer didn't offer it as a benefit. We shared the good news that legislation had been signed into law that would expand health care coverage for someone in his situation. He was disappointed to learn that this coverage would not be available until the winter of 2012. With a smile on his face, he sighed and said, "Well, I guess I just can't get sick until then, right?"

The challenges facing our nation's health care system are significant and must be addressed to ensure the quality of life Americans deserve. Two years ago, the State of Colorado embarked on an amazing journey to improve access to cost-effective, quality health care services for all Coloradans. Heath care has been a top priority of Governor Bill Ritter since he took office in January 2007. In that same year, the Blue Ribbon Commission for Health Care (208 Commission) undertook the study of health care reform models in Colorado. The Commission presented a comprehensive report that provides a bold, yet realistic, blueprint for health care reform in Colorado. Informed by the 208 Commission report and under Governor Ritter's leadership, 100% of the Building Blocks to Health Care Reform agenda in the 2008 legislative session were successfully passed. The package expanded children's health care coverage; increased reimbursement for providers; improved efficiencies in private health insurance and public programs; increased transparency and accountability across the system; and identified further strategies to expand access to cost-effective, quality care. In the 2009 session, the Ritter administration was able to make significant public program expansions and investments in reimbursement rates through passage of a hospital provider fee (HB 09-1293); restructure a statefunded loan forgiveness program for health care providers in rural and underserved communities; pass legislation to allow for private market insurance incentives for wellness programs; and enhance support for emergency services, despite a \$1.4 billion revenue shortfall facing the State.

The Department of Health Care Policy and Financing (the Department) serves as the single state agency responsible for the administration of the Medicaid and the Child Health Plan *Plus* (CHP+) programs. CHP+ is Colorado's program implemented under the State Children's Health Insurance Program (SCHIP). The Department also serves as the lead agency responsible for the implementation of the health care reform initiatives for the State's public health insurance programs. The Department's Executive Director, Joan Henneberry, also serves as the Governor's Senior Health Policy Advisor.

The Department is requesting funding from the Health Resources and Services Administration (HRSA), State Health Access Program (SHAP) for seven comprehensive and interrelated projects totaling \$42,773,029 over five years that we are describing as Colorado's Comprehensive Health Access Modernization Program (CO-CHAMP). CO-CHAMP reflects our responsibility as leaders to "champion" policies that will lead to greater access to health care,

increase positive health outcomes and reduce cost-shifting. When we speak of modernization in the context of the delivery of health care services, it includes making investments in prevention, health information technology, infrastructure as well as understanding which treatments work best for any given health condition. In the context of our proposal, modernization refers to changing the way we do business to expand access to benefits and improve our efficiency by working smarter and better managing our limited resources. It includes making investments in infrastructure and technology, but also includes implementing new strategies around benefit design and cost-sharing. As we think about coverage expansions, it is essential to ensure that our current systems work as well as possible to support the increased caseload. We must build a more productive health care system in the future that will support large coverage expansions. The common thread underlying all of the projects is making the health care delivery system and access to programs more outcomes-focused and client-centered. HRSA's funding of CO-CHAMP will elevate the health care system and Colorado to a new level and position us well for engaging in the national discussion on health reform.

The CO-CHAMP projects are ready to implement and are very well-matched to the goals of the SHAP. The Department requests SHAP funding for the following CO-CHAMP projects:

- 1. **Maximizing Outreach, Retention and Enrollment (MORE)**: The purpose of the project is to design, develop, and implement an outreach plan for the HB 09-1293 expansion populations that generates awareness of the availability of health care coverage programs and the expanded eligibility, and teaches families how to access health care in appropriate settings. It also includes outreach to providers to promote the medical home approach and inform them of the expanded eligibility for previously uninsured people. Over 150,000 currently uninsured will learn about our coverage programs, how to apply, and how to access health care services which leads to a healthier population.
- 2. Eligibility Modernization: Streamlining the Application Process: The purpose of the project is to streamline the application process by replacing paper documentation with electronic data where possible; develop web-based services for clients; and create interfaces to other State and Federal systems to ease data exchange for the HB 09-1293 expansion populations making it easier for clients to apply for public health insurance programs. Over 150,000 currently uninsured will find the application process easier to navigate, application processing times will be dramatically reduced resulting in earlier access to care, and clients will have increased satisfaction with Medicaid and CHP+.
- 3. Childless Adults and Buy-in for Individuals with Disabilities Implementation: The purpose of the project is to develop potential program designs, including models for premium structures, and cost-sharing provisions for the childless adults and buy-in for individuals with disabilities expansion populations. Over 82,000 low-income uninsured adults will have coverage with a benefit package that is evidence-based, promotes value and contributes to the overall improved health for these expansion populations. The Medicaid buy-in program is a key component of the Federal effort to make it easier for people with disabilities to work without losing health benefits. Authorized by the Balanced Budget Act of 1997 (BBA) and the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA), the buy-in program allows states to expand Medicaid coverage to workers with disabilities whose income and assets would ordinarily make them ineligible for Medicaid. The expansion of the buy-in program means more

- than 9,000 individuals with disabilities with family incomes up to 450% FPL will remain eligible for Medicaid while continuing to work at higher paying jobs which promotes their level of self-sufficiency, independence, overall well-being and mental health and increases their life satisfaction.
- 4. **Premium Assistance Program:** The purpose of the project is to expand the CHP+ at Work program statewide to expand coverage to CHP+ eligible children who have access to employer-sponsored insurance. The goal is to have three to four new employer groups participate in the expanded program. The impact of the expansion of the program is that the families of 200 CHP+ eligible children will receive premium assistance resulting in health coverage for their children and access to care.
- 5. **Health Access Pueblo Community Share Expansion.** The purpose of this project is to design, develop and implement an outreach and marketing plan to new businesses on the availability of Pueblo County's community-share program known as the Health Access Program (HAP) to expand coverage to the working uninsured. With expanded outreach and marketing efforts, it is estimated 1,000 previously uninsured workers will have coverage and increase their access to health care services by 2012.
- 6. San Luis Valley Three-Share Community Start-Up: The purpose of this project is to replicate Pueblo County's HAP and create health care coverage for the working uninsured through the San Luis Valley Health Access Program. The program will be designed to create access to services using currently untapped private dollars supplemented with SHAP grant funds during the early years to cover the third leg (the community portion) of the San Luis Valley Health Access Program. The program would move towards sustainability without the need for grants or other sources of governmental funding.
- 7. Weld County Evidence-Based Benefit Design Pilot: The purpose of this project is to create an innovate benefit design tool can be implemented easily and administered efficiently for carriers for the purpose of developing new insurance products targeted at previously uninsured populations. Work on developing this tool and testing the feasibility of this tool will contribute to the benefit design work on the childless adult and buy-in for individuals with disabilities expansion project. If the pilot is successful in Weld County, the benefit tool could be replicated across the State offering the uninsured an affordable and high-quality insurance product.

At the cornerstone of three of the CO-CHAMP projects is House Bill 09-1293 (<u>HB 09-1293</u>), the "Colorado Healthcare Affordability Act" which became law in April 2009. HB 09-1293 has been hailed as the State's most significant health reform in 40 years. This landmark measure provides expanded coverage to more than 150,000 uninsured Coloradans and makes health care more affordable by reducing uncompensated care and cost-shifting, without costing taxpayers or businesses a penny more. The legislation authorizes the Department to generate revenue for provider rate increases and to pay for the coverage expansions through a hospital provider fee and draw down Federal matching funds. Nearly 50 percent of the money generated through the hospital provider fee will be used to provide health care services for the following population expansions of the State's public health insurance programs:

• *CHP*+ *expansion for children and pregnant women* from 205 to 250% of the federal poverty level (FPL) - expands coverage for 24,000 children and pregnant women.

- *Medicaid expansion for parents or guardians* from 60 up to 100% of FPL expands coverage for 43,500 low-income parents.
- Medicaid 12-month continuous eligibility for children.
- *Medicaid expansion for childless adults* with incomes up to 100% of FPL expands coverage for 82,000 low-income childless adults.
- *Medicaid buy-in program for individuals with disabilities* with family income up to 450% of FPL expands coverage for 9,000 individuals with disabilities.

The goal of CO-CHAMP is to improve access to cost-effective, quality health care services for Coloradans. The process measures selected assess the annual progress of each of the seven projects towards meeting the 2010 Healthy People goals on which the five-year CO-CHAMP evaluation is based. Process measures permit the State to adapt and improve the individual program components over the five-year grant period. Additionally, when process measures are effective, HRSA will have the ability to share the model with other states to promote its replication. The following represent the project process measures of CO-CHAMP:

- 1. To implement a comprehensive outreach and marketing plan to increase community awareness of health care coverage programs for expansion populations. This will lead to an 85% penetration rate in children, pregnant women and low-income parents or guardians by year five and a 50% penetration rate in low-income childless adults by year five for the expansion populations.
- 2. To increase capacity of the Department's Healthy Communities Outreach Program to educate expansion populations on program benefits and the importance of preventive care and regular medical visits as evidenced by 85% of enrollees receiving at least one primary care visit per year by year five.
- 3. To implement bi-annual "Enrollment Fair Mini-Grant Program" opportunities for community-based organizations (CBOs) to provide applicants face-to-face application assistance and on-site Presumptive Eligibility determination for children in the expansion population. This will lead to an 85% penetration rate in children in expansion populations by year five.
- 4. To create interfaces between Colorado's eligibility system and other State and Federal databases to increase automated exchange of information to reduce administrative burdens for clients in the population expansions applying for public health insurance programs. This will lead to an increase in the satisfaction with the Medicaid and CHP+ enrollment process in at least 50% of clients (up from 10%) and an 85% penetration rate in children, pregnant women, and low-income parents or guardians and a 50% penetration in low-income childless adults in the expansion populations by year five.
- 5. To implement eligibility system changes that will allow for administrative or paperless verification at renewal through the use of pre-populated forms or *ex parte* determinations for expansion populations. This will lead to an increase in the satisfaction with the Medicaid and CHP+ enrollment process in at least 50% of clients (up from 10%) and an 85% penetration rate in children, pregnant women, and low-income parents and a 50% penetration in low-income childless adults in the expansion populations by year five.
- 6. To expand availability of a web-based online application to serve as a one-stop-shop that allows the expansion populations to screen and apply for benefits as well as check benefits, report changes and renew benefits. This will lead to an increase in the

- satisfaction with the Medicaid and CHP+ enrollment process in at least 50% of clients (up from 10%) and an 85% penetration rate in children, pregnant women, and low-income parents or guardians and a 50% penetration in low-income childless adults in the expansion populations by year five.
- 7. To implement changes in the computerized eligibility system to accommodate automatic enrollment of expansion populations into health care programs using the Free and Reduced Lunch Program information. This will lead to an 85% penetration rate in children in the expansion populations by year five.
- 8. To retain services of a contractor to design, develop and assist in implementation of benefit design, based on stakeholder input, for targeted expansion populations (childless adults and individuals with disabilities). This will lead to a benefit package developed for this population which can be tested and eventually replicated in other states.
- 9. To implement changes in the State's eligibility and claims processing systems to accommodate statewide expansion of the CHP+ at Work program, including the identification of employers to participate in the premium assistance program. This will lead to an additional 200 CHP+ eligible children receiving health care through employer-sponsored insurance as a result of premium assistance.
- 10. To develop and implement a marketing and outreach plan to businesses in Pueblo County to expand coverage of uninsured workers through the multi-share community Health Access Program which will lead to 1,000 new Health Access Program members previously uninsured by 2012.
- 11. To create the San Luis Valley Access Program, a three-share community program, to provide high quality health care coverage with a benefit package that can be offered to low-income uninsured with a cost to workers of about \$60 per month.
- 12. To create an innovative benefit design tool which will lead to an affordable and high-quality insurance product that one or more health plans will offer to previously uninsured populations in Weld County by 2011.

What we are proposing under CO-CHAMP can be likened to putting together a quilt. We have carefully identified all of the distinct pieces that when arranged properly will achieve an orderly and lively design. The proposed projects are designed to provide the uninsured with access to affordable and quality health care coverage. Our approach considers all of the activities that must happen if a client is to obtain coverage and access health care services in appropriate settings. The "life cycle of the client" includes outreach and application assistance; the eligibility determination process; access to health care services; provider recruitment and retention; linking clients to a medical home; and the retention of clients if they continue to be eligible. The legislation has been enacted and the policy decisions made - all of the pieces are ready to be assembled. The HRSA grant funding is the means by which we can join all of the coverage pieces together to fashion the health care coverage and health access quilt. HB 09-1293 serves as the vehicle for the bulk of the coverage expansions while obtaining the HRSA grant funding ensures access to the right health care services in the right places at the right time.

NEEDS ASSESSMENT

Characteristics of Colorado's Uninsured. The Blue Ribbon Commission for Healthcare Reform's (208 Commission) <u>final report</u> included analysis by The Lewin Group (Lewin), that

approximately 785,000 Coloradans – or about 17 percent of the state's population – lacked health coverage in any given month in 2004-2006. Lewin estimated that the number of uninsured would grow to nearly 792,000 by 2008.

Nearly 300,000 of the uninsured are associated with workplaces that do not offer coverage to any employees. More than two-thirds of the uninsured live in families where one or more people are working. For nearly 140,000 uninsured Coloradans, the worker in the family is a part-time or temporary employee and not eligible for coverage. Another 87,000 or 11 percent of workers and their dependents have declined coverage made available to them by employers. Seventy percent of the uninsured are in the workforce (or are the dependent of a worker). Approximately 21 percent are ineligible for their employers' coverage. Approximately 37.5 percent of Colorado's uninsured are employed by firms that do not offer health coverage to their employees.

The uninsured are found in all income groups. About 32 percent of the uninsured live in households that earn \$20,000 or less annually and almost 75 percent live in a household with an annual income of \$50,000 or less. Approximately 13 percent are in households that earn \$75,000 or more annually while 6.5 percent are in households that earn more than \$100,000 annually.

Young adults are more likely than any other age group to lack insurance: about 40 percent of the uninsured are between the ages of 19 and 34. Close to 20 percent of the uninsured are children 18 and under. About 85,000 uninsured people in Colorado are eligible for Medicaid or CHP+ but not enrolled. Of those, more than 70,000 are children. About 6,000 are ages 19 to 34, and another 9,000 are ages 35 to 64. Approximately 21 percent of the uninsured are not citizens of the United States (either legal non-citizens or undocumented).

The percentage of the population without coverage varies widely by race and ethnicity. About 30.3 percent of people who report they are Hispanic are without health insurance coverage which is significant when you consider that persons of Latin or Hispanic original constitute 20 percent of Colorado's total population. Approximately 14.5 percent of blacks are uninsured, compared with about 13.7 percent of whites. Of the total number of uninsured (785,000), about 57.4 percent of the uninsured are white. Hispanics account for 35.7 percent of those without health insurance. About 3.3 percent of the uninsured are black and about 3.6 percent report they are in "other" racial groups.

It also matters where you live. In 2000, the seven counties with the highest uninsured rates – as high as 29 percent – were all in southern Colorado commonly referred to as the San Luis Valley. The next highest rates were in counties on the Eastern Plains. The suburban counties around Denver had some of the lowest uninsured rates.

Even if you do have insurance or are eligible for a public program such as Medicaid, you still may not have ready access to health care. Individuals who are publicly insured often face barriers to health care because a growing number of providers are unwilling to accept patients insured by these programs because of low reimbursement rates. Medicaid eligibility rules are complex and categorical in nature, resulting in many Medicaid enrollees finding it difficult to identify providers willing to accept them as patients. Progress is being made in Colorado due to a Department budget initiative that raised reimbursement for primary care. In fact, 84 percent of

all primary care providers in Colorado now participate in Medicaid and CHP+. We continue to work with our providers to increase the number of Medicaid and CHP+ clients they serve.

CO-CHAMP Projects and the Uninsured. CO-CHAMP proposed projects were specifically chosen because of their potential impact on reducing the number of uninsured in Colorado. Figure 1.1 summarizes the characteristics of the target population and the numbers of uninsured who would be eligible for coverage under CO-CHAMP:

Figure 1.1: CO-CHAMP Coverage Expansions and Impact on the Uninsured

Expansion Population: CHP+ Expansion to 250% of FPL: Children and Pregnant Women

Need: 20 % of uninsured in Colorado are children

Impact (Coverage): Caseload Increases Over Next Five Years: SFY 09-10: 6,300 children; 750 pregnant women; SFY 10-11: 14,700 children; 1,750 pregnant women; SFY 11-12: 18,900 children; 2,250 pregnant women; SFY 12-13: 21,000 children; 2,500 pregnant women; SFY 13-14: 21,400 children; 2,600 pregnant women

Expansion Population: Parents to 100% of FPL; Parents of children who are eligible for Medicaid or CHP+

Need: 32 % of insured live in households that have household incomes less than \$20,000; an extensive body of research shows that covering low-income parents increases enrollment by eligible children in health insurance programs, which reducing the number of children who are uninsured (Center on Budget and Policy Priorities 2006)

Impact (Coverage): Caseload Increases Over Next Five Years: SFY 09-10: 12,900 parents; SFY 10-11: 30,100 parents; SFY 11-12: 38,700 parents; SFY 12-13: 43,000 parents; SFY 13-14: 43,500 parents

Expansion Population: Medicaid Expansion to Childless Adults to 100% of FPL

Need: Young adults are more likely than any other age group to lack insurance: about 40% of the uninsured are between the ages of 19 and 34; 32% of insured live in households that have incomes less than \$20,000

Impact (Coverage): Caseload Increase Over Next Five Years: SFY 11-12: 16,400 childless adults; SFY 12-13: 49,200 childless adults; SFY 13-14: 82,000 childless adults

Expansion Population: Medicaid Buy-in to 450% of FPL for individuals with disabilities

Need: Medicaid buy-in breaks down the barrier to adequate health coverage and permits workers with disabilities to enter the work force or secure higher-paying jobs, strengthening the state's economy and a person's independence

Impact (Coverage): Caseload Increase Over Next Five Years SFY 11-12: 3,800 disabled individuals; SFY 12-13: 7,600 disabled individuals; SFY 13-14: 9,000 disabled individuals

Expansion Population: CHP+ at Work Premium Assistance

Need: Families earning between 200% and 400% FPL have some income available to spend on health care, but cannot afford health insurance without a substantial subsidy; when families spend more than 5 percent of their household income on health care, they make substantial tradeoffs on other important expenditures such as transportation, housing and child care; 70 percent of the uninsured are in the workforce (or are the dependent of a worker); about 11 percent of uninsured workers and dependents are eligible for but do not take the coverage offered by their employer

Impact: One employer participates in the current pilot program; Statewide expansion will result in 3 - 4 new employer groups and 200 new CHP+ enrollees

Expansion Population: Working uninsured in Pueblo County through a Community Multi-Share Expansion

Need: Pueblo County's population is 144,681 and the uninsured rate is 14.2%; Pueblo County has 3,991 employers with fewer than 50 employees; 40% of population in Pueblo County is of Latin or Hispanic origin and 30.3 percent of this group are without health insurance

Impact: 1,000 previously uninsured will have coverage through the Health Access Program by 2012

Expansion Population: Working uninsured in San Luis Valley through Three-Share Community Pilot

Need: The San Luis Valley is comprised of 6 counties all designated either rural or frontier and all designated as Health Professional Shortage Areas (HPSA) by the Health and Human Services (HHS) agency; small employer groups with 1 to 4 employees make up 68 percent of the employer marketplace; groups with 5 to 50 employees are 30% with only 2% being employers with over 50 employees; less than 37 percent of employer groups with less than 10 employees offer health insurance, only 53 percent of groups with 10 to 24 employees offer insurance, according to the Agency for Healthcare Research and Quality; 24% of the population is uninsured

Impact: 5,000 individuals not currently covered would be eligible for program

Expansion Population: Working uninsured in Weld County through Evidence-Based Benefit Design Pilot

Need: 45,994 people, or 21.6% of population are uninsured; a little over 20% of the population live in homes where a language other than English is spoken; 27% of the County's population is of Latin or Hispanic origin; Weld County is home to a large number of small businesses – approximately 75 percent of all businesses in Weld County have nine or fewer employees; in 2004, 42 percent of jobs in small to mid-size businesses in Weld County did not offer any health insurance to workers

Impact: The development of an insurance product offered as a pilot by one or more licensed insurance plans that use the benefit development tool as the basis of the coverage and access to care for the uninsured in Weld County

Key Health Issues Related to Access to Care and Uninsurance: The State Colorado Department of Public Health and Environment (CDPHE) houses the State's Colorado Primary Care Office and functions to lower the barriers that prevent Coloradans from receiving adequate primary, oral and mental health care. The Primary Care Office is funded by a Federal grant from HRSA. In a November 2006 report, CDPHE summarized a variety of health indicators based on People 2010 objectives. Colorado leads the nation with the lowest obesity rate (16 percent). However, the proportion of adults who are obese now exceeds the HP 2010 target of 15 percent. Colorado ranks 44th in the country for access to prenatal care. Nearly one in five mothers (or twice the HP 2010 target) report that they did not receive adequate prenatal care. Colorado ranks in the bottom 10 states for its high rate of low-weight births (HP 2010 target is 5 percent while Colorado's rate is 9 percent). Only 77 percent of young children receive the entire series of recommended vaccinations by 19 to 35 months of age.

Compared with other states, the overall quality of health care in Colorado is considered "average," down from a recent rating of "strong," according to the Federal Agency for Healthcare Research and Quality. Although Colorado is considered to be the thinnest state in country, low-income children have three times the obesity rate as higher income children. For adults enrolled in Medicaid, the smoking rates are double the state average.

The 2007 Commonwealth Fund State Scorecard on Health System Performance ranks Colorado 35th among states for "access" as measured by the number of adults and children that are insured. Colorado ranks 43rd in "equity" as measured in differences in performance associated with patients' income level, type of insurance or race or ethnicity. Colorado ranks 30th in "quality" measured by the recommended screenings and preventive care for adults and children, usual source of care for adults and children, appropriate care and patient satisfaction.

Colorado based its decision to expand coverage for low-income parents, childless adults, low-income children, and individuals with disabilities based on national and state data supporting the populations that were our most vulnerable in terms of their health status as it related to income and the likelihood that these groups were currently uninsured. Further, these expansions were all recommended by the Blue Ribbon Commission for Health Reform.

Colorado in SFY 2007-08 which is 77 percent more than what was spent in Colorado in 2000. The total includes payments by individuals, employer contributions and spending for hospitals, physicians, dentists, prescription drugs and long-term care. Hospitals, physicians and prescription drugs are among the fastest-growing categories of health care spending in Colorado. Coloradans also are spending much more for insurance coverage. The cost of covering a family in Colorado more than doubled from 1996 to 2003, a greater increase than the average 87 percent rise seen nationally and much larger than inflation and wage increases over the same period. Like much of the rest of the country, one of the primary reasons for higher premiums is the cost-shifting that takes place. When doctors and hospitals care for the uninsured, much of the cost is shifted to private insurance. In 2005, premiums for families with insurance through an employer were, on average, \$934 higher due to the unreimbursed cost of treating uninsured patients.

Source of Insurance. Today, nearly 60 percent of Coloradans are covered by health insurance through a workplace. Our primary public health insurance programs, Medicaid and CHP+ cover approximately 10% of the state's population. Of the 57.1 percent of employer sponsored insurance, 7.8 percent represents small group employers; 19.6 percent represents large group employers; and 30.9 percent represented ERISA self-funded employers.

Seven health plans compose much of the privately insured managed care market in Colorado. Aetna Health Inc., CIGNA HealthCare of Colorado, HMO Colorado, Kaiser Permanente, PacifiCare of Colorado, Rocky Mountain Health Plans, and United Healthcare of Colorado have over 800,000 managed care members. In the individual market, approximately 300 companies wrote some individual coverage in 2006, although 45 companies wrote 90 percent of the policies. In the small group market, 21 carriers wrote small group coverage in 2006, although ten companies wrote 95 percent of the business. In the large group market, 247 companies wrote some large group coverage with 26 companies writing more than 90 percent of the total.

Approximately 15 percent of our Medicaid clients are enrolled in Medicaid managed care programs at Denver Health and Hospital Authority, Rocky Mountain Health Plans, Colorado Access and Kaiser Permanente and the remaining 85 percent are enrolled in fee-for-service plans. The CHP+ program has 64,698 enrollees as of April 2009 and 100 percent are in managed care plans at Denver Health and Hospital Authority, Rocky Mountain Health Plans, Colorado Access, Kaiser Permanente and the State Managed Care Network.

The Department is proposing new innovative ways to ensure that all of our clients' care is managed and that clients have access to high quality health care that results in positive health outcomes. For example, to address the complexity and high costs associated with fee-for-service Medicaid, Colorado is one of seven states participating in the "Rethinking Care Program for America's Highest Need, Highest Cost Populations" program. This program was started in January 2008 by the Center for Health Care Strategies and is known in Colorado as the "Colorado Regional Integrated Care Collaborative" (CRICC). The goal of the program is to better manage the care and costs of the highest need, highest cost clients. The Department contracted with Colorado Access in May 2008 in several front-range counties and has enrolled over 2,000 clients in the program. Colorado Access is a network of federally qualified health centers, specialists, and safety net hospitals.

The Department is also initiating plans for the comprehensive reform of the Medicaid program which will shift priorities from the system to the clients and providers. The Accountable Care Collaborative is part of the Medicaid reform effort and was approved by the Colorado Legislature in the 2009 session. It is envisioned to consist of a statewide data and certification organization and a number of regional care coordination organizations. These regional organizations will be charged to offer care-coordination services and to support the local participating providers and clients in the regions. In exchange for the additional clinical support, providers will be asked to offer increased access to clients (extended office hours, some sameday appointments, etc.) and to begin to use state-supplied health information technology. The Department plans to implement the program by July 1, 2010 starting with 60,000 clients. If the program can demonstrate success by improving clinical outcomes and producing cost savings among Medicaid clients, it could be expanded in later years.

Role of the Safety Net in CO-CHAMP. Although several health insurance carriers do business in Colorado, few have service areas in Colorado's many rural and frontier counties making it difficult for Coloradans in those areas to access care. In addition to geographic isolation, other factors make it difficult to access primary health, dental and mental health care including being uninsured, a lower level of income, inability to afford basic coverage, and cultural, language and other social barriers. Some areas in Colorado have an inadequate supply of providers who are willing to accept Medicaid enrollees into their practices making it difficult for those enrolled public insurance to access needed care.

Colorado's safety net providers serve as the source of care for the growing number of vulnerable Coloradans and face increasing financial stress and capacity constraints in providing health care as the number of uninsured and underinsured continues to rise. Our core safety net providers include Community Health Centers (CHCs), also known as Federally Qualified Health Centers

(FQHCs); local public health departments/public nursing services; other community-based clinics; rural health clinics; and school-based health centers.

In terms of access to health care services, 47 of Colorado's 64 counties are designated as rural. Of these, 13 do not have a hospital, 28 have no community resource center, 13 have no rural health clinic and three do not have any local health care resources. In addition, six rural counties do not have a full-time primary care physician, and eight have only one full-time primary care physician to meet their health care needs as well as those of surrounding communities. Access to oral health is even more limited as evidenced by seven counties in Colorado which have no dentists to treat patients.

While all of these safety net providers will play an important role as we expand coverage to new populations, the Department anticipates that Colorado's CHCs will be pivotal in serving the health needs of these new populations. Currently, CHCs provide a health care home to more than 500,000 of their community members - one in 10 people in Colorado. CHCs provided more than \$1.6 million medical, dental and mental health visits in 2007. Fifteen CHCs operate 120 clinic sites in 34 Colorado counties and care for patients living in 54 counties. Additionally, 12 CHCs operate 31 dental clinic sites in 19 Colorado counties and provided 170,000 visits to more than 71,000 patients in 2007. CHCs care for one-third of all low-income uninsured in Colorado; one-third of all Medicaid enrollees; and one-third of all CHP+ enrollees. Ninety-three percent of patients served have family incomes below 200 percent of the FPL.

CHCs will play an integral role in Colorado's health care expansion program. CHCs will work to ensure that those patients who are uninsured and eligible for the expansion apply and become covered through the new program. To accomplish this, CHCs will provide outreach and application assistance to individuals and families eligible for coverage through the expansion as part of their ongoing FQHC responsibilities. Once enrolled, CHCs will become a health care home for and provide comprehensive primary care to thousands more individuals. As more of the CHCs uninsured population becomes covered through the expansion program, CHCs may have the capacity to see additional uninsured patients.

Use of Medical Homes in CO-CHAMP. Thanks to the leadership of the Ritter administration, a coalition of community groups and concerned legislators, the "Medical Homes for Children" legislation was signed into law that established the standards and measures of the medical home model with the goal that every child enrolled in a public health plan have a primary care provider responsible for delivering timely and appropriate care. Working with many community groups, the Department implemented this legislation and began to increase provider reimbursement and improve other essential administrative services. By February of 2009, more than 90 percent of Colorado pediatricians were accepting Medicaid and CHP+ patients, and, most significantly, an estimated 90,000 more children enrolled in Medicaid have a medical home. Over 62,000 children enrolled in CHP+ have a medical home.

Recently, the Department reported their preliminary results to the state legislature indicating that, in collaboration with the Colorado Children's Healthcare Access Program (CCHAP), children enrolled in a medical home had: "increased incidence of low-cost preventive care......emergency department utilization was reduced and less expensive for children.....

fewer children were admitted to the hospital with a lower cost per admission.....[and] the enrollment for medical homes for children continues to increase at a steady pace as practices request to join either through the Department or the CCHAP programs."

For our HRSA funded projects that expand coverage to children, the Department intends that every child that enrolls in CHP+ have a medical home through our established processes. For HRSA funded projects that expand coverage to adults, the Department plans to build on the framework established under the medical homes for children and integrate the approach and concept into its new Accountable Care Collaborative model described earlier. The Department is fully committed to ensuring that all of its clients have care that is accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally competent.

Infrastructure Barriers in the State and How CO-CHAMP Will Overcome These Barriers.

Colorado is a state-supervised, county-administered system for the administration of medical assistance programs. Colorado's 64 counties serve as the agents of the Department but have 64 different models for organizing their eligibility and enrollment activities.

As part of Governor Ritter's "Building Blocks for Health Care Reform," the Department launched the Colorado Eligibility Modernization Project in the spring of 2008. The goal of the eligibility modernization project is to find the best ways to enroll and retain children and families in our public health insurance programs.

Based on eligibility site visits in Colorado, the study of best practices and lessons learned from other states, Public Knowledge, the Department's contractor, identified a substantial number of deficiencies in the Medicaid and CHP+ eligibility and enrollment process as follows:

- The overall model utilized in Colorado is outdated and does not fit current workload and demographic trends.
- The current model is confusing to many clients and hinders access to programs.
- The current model fosters inconsistencies in the timing and manner in which eligibility determinations are made.
- The current model lacks accountability.
- The eligibility model is hindered by a reliance on paper documentation, limiting organizational options for managing the workload.
- The Colorado Benefits Management System (CBMS) still does not fully support Medicaid and CHP+ eligibility.

One of the "best practices" identified by Public Knowledge was how many states are creating interfaces to other state and Federal databases to increase automated exchange and reduce the amount of data entry required of their eligibility technicians. With the Deficit Reduction Act's mandate that requires originals or certified copies of identification and citizenship documentation with each application, real-time interfaces are even more crucial to the efficiency of application processing. A large number of applications submitted are "pended" - the eligibility determination cannot be run - because of the lack of the required verifications. We are proposing to use SHAP funding to establishment these interfaces between CBMS and other state and Federal systems for the expansion populations. With 150,000 new clients soon to be eligible for

our programs, there exists a sense of urgency to create efficiencies and build operational capacity within the application processes.

The Department was appropriated funding to build a web-based online application for the current Medicaid and CHP+ population that will be fully integrated with CBMS. The Department proposes to utilize SHAP funding to enhance the web-based online application to cover the disabled and adult expansion populations. A centralized online application and client tools will promote consistent practice among the eligibility sites and community-based organizations (CBOs), as well as minimize confusion for clients by providing a single website to access. The web-based online application will be fully integrated into CBMS which will maximize efficiency and reduce the amount of data entry on local eligibility technicians. Most importantly, the sooner a client's eligibility can be determined, the sooner the client can access health care in appropriate settings and have a medical home.

Based on data from a variety of sources, we know significant challenges exist with respect to retaining clients that remain eligible for our programs. With planned coverage expansions, w need to protect our investment in outreach and find ways to retain children on our programs if they remain eligible. We propose using SHAP funding to make modifications to the renewal form in CBMS for all of the new expansion populations as well as implementing changes to CBMS to allow for passive re-enrollment. These changes will greatly improve our retention rates and increase the likelihood that clients continue to receive needed health care services without interruption. HB 09-1293 also includes provisions to fund continuous eligibility for children demonstrating policy-maker support for keeping children enrolled.

History of State's Past Efforts to Reduce the Number of Uninsured. In March of 2001, Colorado received a HRSA State Planning Grant and had begun active work on its grant that summer. At that time, Colorado's economy was beginning to feel the impact of the nationwide economic slowdown, especially in the technology sector. After the events of September 11, however, Colorado experienced the same exacerbations of the slowdown as the rest of the country and any discussion of health care expansions were tabled. With HRSA funding, Colorado conducted the largest telephone survey (10,000 households) in the State's history on health care coverage issues. The survey, completed in late summer 2001, allowed Colorado to measure, for the first time, coverage variations across health care marketplaces and regions.

In 2004, a citizen-initiated ballot measure increased tobacco taxes for health programs. The tobacco tax for health care measure, known as Amendment 35, passed with 62 percent voter support. The General Assembly passed implementing legislation in 2005 (House Bill 05-1262), which dedicated more than 50 percent of the revenue to access to healthcare for low-income working Coloradans. A significant portion is used to support Medicaid and CHP+ eligibility expansions and other share is used to support Federally Qualified Health Centers and other safety-net primary care clinics serving publicly insured and uninsured Coloradans. The remaining tobacco tax revenues fund tobacco education and cessation programs and tobacco-related disease prevention, detection and treatment.

One of the most important lessons learned from the experience is the fact that leadership is essential for any health care reform initiatives that contemplate population expansions. While

health care was not a high priority area for former Colorado Governor Bill Owens, he did sign into law legislation that created the 208 Blue Ribbon Commission on Health Care Reform and work commenced during his term. Most likely, Colorado's interest in health care reform was sparked by the national attention Massachusetts was receiving as a result of their innovative health care initiatives.

When Governor Bill Ritter was elected in 2006, he made health care one of the cornerstones of his campaign and of his administration. Under Governor Ritter's leadership, Colorado has emerged as a state to be watched with respect to health care coverage, access and quality as described throughout this proposal.

Colorado's Political and Economic Landscape and Impact on Success of CO-CHAMP. In January 2009, VectraBank Colorado's chief economist offered the opinion that Colorado is about two-thirds of the way through a recession that will end in late 2009, although Colorado has certainly not been immune to effects of the national recession. The State had to close a budget gap of more than \$1 billion for SFY 2009-10. On May 1, 2009, Governor Bill Ritter signed the \$19.2 billion SFY09-10 budget which reflected the State's commitment to ensuring vital safety net services will continue for our most vulnerable populations - for people who live at the margins. We do not anticipate the budget situation will have any adverse impacts on expanding coverage to populations identified in this grant because the expansions will be financed through the collection of the hospital provider fee as outlined earlier in the proposal.

Politically, Colorado tends to be more moderate and independent-minded. Colorado currently has a Democratic governor and controls both chambers of the state legislature. The recently enacted "Healthcare Affordability Act" (HB 09-1293) had widespread bipartisan support. In 2004, voters passed Amendment 35 that increased taxes on tobacco and directed that the majority of the funds go towards funding health care initiatives. Amendment 35 passed with more than 60 percent of the voters and public opinion research shows that health care consistently ranks among the top three issues of concern for Colorado voters.

The Influence of National Activities and Other States' Activities on Colorado. Over the past several years, all eyes have been focused on Massachusetts as it passed a comprehensive set of health care reforms in 2006. One of the most important lessons learned from Massachusetts was the importance of public-private partnerships and much of their success can be attributed to this approach. Colorado has also experienced great success in expanding coverage through this public-private approach. In fact, Colorado's SCHIP program is modeled after a private health care insurance model and much of the general acceptance and success of the program can be ascribed to the public-private partnership. Another example of the public-private partnership approach is HB 09-1293. The Department, the Colorado Hospital Association and the Governor's Office worked together for nearly a year to develop this legislation which passed both the House and the Senate quickly with more than 40 co-sponsors and bipartisan support.

To a great extent, all of the proposed projects in our grant proposal were shaped by researching the best practices and lessons learned from other states and reflect the priorities identified by our Blue Ribbon Commission for Health Care Reform. We also sought advice from key national health care policy analysts and availed ourselves of the opportunity to learn from others by

participating in national meetings and conferences. Much of our work for our eligibility modernization project was informed by a national conference sponsored by the Center on Budget and Policy Priorities. Many of the recommendations for eligibility modernization advanced by Public Knowledge were inspired by best practices from other states. The three-share community projects described in our HRSA grant proposal were modeled after the Muskegon Community Health Program. Colorado is looking to other states like Maine and Massachusetts to learn from their experiences in expanding coverage to childless adults. Part of our eligibility modernization proposal incorporates the concepts of "Express Lane Eligibility" as part of the Children's Health Insurance Program Reauthorization Act (CHIPRA) federal legislation.

Joan Henneberry, the Executive Director of the Department and Governor Ritter's Senior Health Policy Advisor, is a nationally recognized leader on health care policy issues. She spent three years as Director of the Health Policy Studies Division, Center for Best Practices at the National Governor Association (NGA) in Washington, D.C. In this position, Joan provided technical assistance and consultation to governors and their staffs on health care services and financing, cost and insurance trends, containment efforts and emerging policy issues. Because of Joan's leadership and national prominence, we have had considerable opportunities to benefit from the expertise of national and state health care policymakers. We find ourselves emerging as a state that other state and national leaders can turn to for advice and guidance in areas like the medical home, quality initiatives, and payment reform.

In crafting the projects under CO-CHAMP, we have gathered a tremendous amount of research and information that will serve as the foundation for the successful implementation of these projects. Because of the page limitation of the grant application, we were not able to include the complete Work Plan and methodology for each of these projects. It is our intent to create a Resource Guide that will serve as our roadmap for moving forward. This Resource Guide and our detailed Work Plans will be available to share with other states. Our CO-CHAMP projects are innovative and embrace some of the latest recommendations of national health care policy experts. We are confident that the CO-CHAMP projects are very relevant lend themselves to replication in other States.

Figure 1.2: Data Supporting Need for CO-CHAMP Projects

The Lewin Group, "Technical Assessment of Health Care Reform Proposals," Aug. 20, 2007. Final Report

Colorado Department of Health Care Policy and Financing Budget Analyses and Reports. HCPF:Budget

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"Low-Income Adults Under Age 65 —Many are Poor, Sick, and Uninsured," Kaiser

Commission on Medicaid and the Uninsured, June 2009, Low Income Adults

"Medicaid as a Platform for Broader Health Reform: Supporting High-Need and Low-Income Populations," Kaiser Commission on Medicaid and the Uninsured, May 12, 2009, Medicaid Broader Health Reform

Feder, Elizabeth, PH.D., "The Cost of Care: Can Coloradans Afford Health Care," Colorado Center on Law & Policy, April 2009, <u>Affordability Study</u>

Broaddus, Matt and Keighton Ku, "Coverage of Parents Helps Children, Too," Center on Budget and Policy Priorities, October 20, 2006, Coverage of Parents Helps Children, Too

State Health Access Data Assistance Center (SHADAC) State Profile: Colorado, December 2007, SHADAC State Profile: Colorado

"The State of Colorado's Health Care Safety Net," Colorado Health Institute, May 4, 2009, Colorado's Health Care Safety Net

METHODOLOGY

Start-Up Costs for CO-CHAMP. For the CO-CHAMP projects related to the expansion populations identified in HB 09-1293, the revenue generated by the hospital provider fee is to supplement current State General Fund appropriations to support hospitals. If revenue from the fee is insufficient to fully fund the coverage expansions and associated administrative costs, the General Assembly is not obligated to appropriate General Fund. Payments to hospitals must be fully funded before any eligibility expansion. Because the State wanted to ensure that sufficient provider fees are generated to both support hospitals and expand coverage, the State limited the administrative costs to those activities are essential to successfully implement the coverage expansions under the legislation. Many activities that would augment the success of the coverage program like outreach and the implementation of eligibility modernization were tabled while new funding sources were pursued. HB 09-1293 serves as the vehicle for the coverage expansions while obtaining the HRSA grant funding ensures access to the right health care services in the right places at the right time. For the CHP+ at Work project, the Department will use existing resources to gather the requirements to make changes to two information technology systems used by the Department: the Colorado Benefits Management System (CBMS) and the Medicaid Management Information System (MMIS). The CBMS tracks client data, determines eligibility, and calculates benefits for medical, food, and financial assistance programs. MMIS is an automated claims, capitation processing and reporting system. The CHP+ program staff will prepare the Request for Proposal (RFP) for the marketing and recruitment contractor scope of services. The Health Access Pueblo Community Multi-Share Expansion is in place and is using existing resources to manage and promote the program. However, the funds requested under SHAP will offer additional resources to conduct an optimal marketing and advertising campaign in Pueblo County. The San Luis Valley Three-Share Community Start-Up project has grant funding along with local matching funds to cover start-up costs. SHAP funding would initially be used to cover the third legal of funding required to pay for health care services provided to those employees who participate in the program. For the Weld County Evidence-Based Benefit Design Pilot project, the Dr. A.J. Kauvar Foundation funded initial work on this plan for a transparent, evidence-based high-value benefit tool. This project builds upon the work performed during this initial phase as well as work from the Centennial Care Choices program.

State and Federal Statutory and Regulatory Requirements. The following provides a status of the required Federal and State legislation needed to implement CO-CHAMP as well as the regulatory requirements that must be met.

- Maximizing Outreach, Retention and Enrollment (MORE): HB 09-1293 authorized coverage expansions; no other statutory or regulatory changes are needed.
- Eligibility Modernization: Streamlining the Application Process: HB 09-1293 authorized coverage expansions; HB 09-1020 calls for the establishment of phone and Internet-based systems for re-enrollment in public insurance programs; SB 08-161 permits a simplified verification process with respect to income for both initial eligibility determinations and for re-determinations; no other statutory or regulatory changes have been identified at this time.
- Childless Adults and Buy-in for Individuals with Disabilities Implementation: HB 09-1293 authorized coverage expansions; new adult expansion would require an 1115 demonstration waiver from the Federal Centers for Medicare and Medicaid Services (CMS); proposals are subject to CMS, Office of Management and Budget (OMB), and Department of Health and Human Services (HHS) approval. A State Plan Amendment is also required.
- **Premium Assistance: CHP+ at Work:** In September 2006, through a Federal waiver, the Federal government authorized the CHP+ at Work program; no further statutory or regulatory changes are needed to expand the program statewide for the population expansions.
- **Health Access Pueblo: Community Multi-Share Expansion**: HB 07-1022 was enacted into law in June of 2007 authorizes the Pueblo Board of County Commissioners to contract with the Health Access Program to provide high quality health care coverage to qualified persons who work for firms based in Pueblo County; no further statutory changes have been identified at this time.
- San Luis Valley: Three-Share Community Start-Up: HB 09-1252 allowed for expansion of the "Local Access to Health Care Pilot Program Act to allow creation of a pilot program in the San Luis Valley to address the health care needs of the uninsured population; no further statutory changes have been identified at this time.
- Weld County: Evidence-Based Benefit Design Tool: The implementation of a pilot project will require exemption from the current state insurance coverage mandates. The Department, in conjunction with the Governor's Office, will work closely with the project team to determine at what point legislation is appropriate or required.

20 Percent Matching Requirement. The Department proposes to use the HRSA grant funding to enhance the Department's current efforts towards the Eligibility Modernization Project and expansion of health care for people with disabilities and adult expansion populations. The Department has been appropriated limited State General Fund for the Eligibility Modernization Project and has the authority to use a limited amount of future revenues from the hospital provider fee to assist in the implementation of the expansion populations. These funds can be utilized as the State's share, which will exceed 20% of the proposed project's total budget.

HRSA Funded Projects Total						
	HRSA Year 1	HRSA Year 2	HRSA Year 3	HRSA Year 4	HRSA Year 5	
Total	\$20,970,202	\$20,339,433	\$19,786,153	\$21,900,984	\$24,965,652	
State Funds	\$5.064.004	\$4,724,582	\$5,612,465	\$6,610,779	\$7,692,640	

Federal Medicaid Matching Funds	\$5,940,587	\$5,823,888	\$6,816,321	\$7,912,671	\$8,996,461
HRSA Funds	\$9,965,612	\$9,790,964	\$7,357,368	\$7,377,534	\$8,276,551
Percent State Funds to Total Funding	24%	23%	28%	30%	31%

Sustainability. The Department will use ongoing base resources appropriated under House Bill 09-1293 to sustain the eligibility modernization and outreach programs proposed in its request for HRSA funding. In addition, the county administration workload study proposed for year 5 of the HRSA grant will help demonstrate how eligibility modernization has made the eligibility and redetermination process more efficient and reduced the workload to counties possibly reducing County Administration in the future. In addition, to retain some of the FTE after HRSA year 5, the Department will request additional state funds through its regular budget process using evaluation benchmarks and outcomes as strategic planning guides. Finally, the Department anticipates that the additional providers recruited through CO-CHAMP will enhance client access to public medical assistance programs over the long-term, and contribute to better health and satisfaction outcomes for clients and cost savings overall for state and federal funding sources. Please see Budget Summary, Page 6, Sustainability Funding for additional detail.

The CO-CHAMP **Work Plan** that is submitted as Attachment 3 offers a description and timetable for tasks to be conducted pre-implementation and post-implementation. It also identifies those parties responsible for completing project tasks as well as the outcomes and performance measures for those outcomes where appropriate. The Department has a much more detailed Work Plan available upon request that was not submitted due to the page limitations of this grant application. The CO-CHAMP **Budget Narrative** also provides a considerable amount of detail that correlates the project activities to the SHAP funding requested over the five year grant period.

CO-CHAMP Private and Public Collaborators, Contractors, and/or Supporters.

Throughout the SHAP grant application process, the Department has experienced widespread support, enthusiasm and assistance from other State agencies, providers, community-based organizations as well as local health care policymakers. In fact, the Department received more letters of support from organizations offering substantive assistance in the implementation of CO-CHAMP than the page limitation would allow us to submit. The following represents the groups associated with each CO-CHAMP project:

- Maximizing Outreach, Retention and Enrollment(MORE): County Departments of Health and Nursing Services, Memorial Hospital, Colorado Community Health Network, Community Health Centers, Family Resource Centers, Northwest Colorado Visiting Nurses Association, Family Voices Colorado, Pueblo Step-UP, Colorado Coalition for the Medically Underserved, Denver Public Schools, Covering Kids and Families, 2010 Coalition.
- Eligibility Modernization: Department of Human Services, Department of Public Health and Environment, Department of Revenue, Department of Labor and Employment, County Departments of Human Services, Colorado Health Foundation, Colorado Children's Campaign, Colorado Community Health Network.
- Childless Adults and Buy-In Program for Individuals with Disabilities: Colorado Cross Disability Coalition, Single Entry Points (SEPs), Community Centered Boards (CCBs),

- Colorado Health Care Association, Colorado Association for Home Services and Aging, Colorado Association for Durable Medical Services, Consumer Based Attendant Support and the Colorado State Ombudsman.
- **CHP+ at Work Premium Assistance Program**: City and County of Denver, Kaiser Permanente, Rocky Mountain Health Plans, Denver Health (already participates, but more employees will be eligible due to expansion).
- Community Multi-Share Expansion Programs and Evidence-Based Benefit Design Pilot: The Adams Group, Dr. A.J. Kauvar Foundation, Health Access Pueblo, Rocky Mountain Health Plans, San Luis Valley Regional Medical Center, San Luis Valley Health Maintenance Organization, Division of Insurance, Weld County.

Strategies to Disseminate HRSA Funded Program Information. The Department will employ its stakeholder network of providers, advocacy groups, business leaders, insurance companies and State and local government agencies to disseminate the outcomes and lessons gleaned from CO-CHAMP activities. The Department collaborates with the Colorado Department of Public Health and Environment (CDPHE), which collects, analyzes and disseminates data on population health—including measures that directly relate to the Healthy People 2010 Leading Health Indicators. Moreover, CDPHE reports data into national databases, and the Department will ensure that such data captures information about the populations touched by CO-CHAMP activities. Data specific to the populations served by the Department, as they relate to CO-CHAMP activities, will be collected, analyzed and disseminated by the Department. As the implementation of our evaluation plan provides us with information on outcomes and lessons learned from CO-CHAMP activities, the Department will communicate the information to stakeholders by holding meetings and publishing reports on a regular basis. These outcomes and lessons learned, along with input from stakeholders, will then inform the development of new goals and drive improvement plans. The Department is responsible for frequent, regular data and information reporting to the Centers for Medicare and Medicaid Services (CMS), which in most cases, feeds into national databases. Furthermore, the Department participates in a number of national surveys, such as those distributed by the National Academy for State Health Policy and the National Association for State Medicaid Directors—all of which will contain information resulting from SHAP activities.

CO-CHAMP Project Design, Scope and Project Activities.

1. Maximizing Outreach, Retention and Enrollment ("MORE")

Background. While funding has been appropriated under HB 09-1293 to pay for health care services for the expansion populations and some limited administrative costs, additional funding is needed to maximize the enrollment of eligible persons and ensure coordinated and efficient delivery of services to these new populations. For example, 158,500 additional people are expected to have health care coverage by SFY 2013-14. At the time of the fiscal note preparation, it was assumed that the Department would continue to receive \$2.7 million in outreach funding to implement marketing and outreach campaigns that would target these new expansion populations. Because of the State's budget crisis, \$1.4 million in outreach funding was cut from the budget and it is highly improbable that this outreach funding will ever be restored to its past levels. Without adequate funding, it will be challenging to reach the 150,000

people, many of whom have little or no direct experience in applying for public health insurance programs. While funding in HB 09-1293 serves as the foundation for expanding coverage, the HRSA grant funding will be used to conduct effective outreach and marketing campaigns to inform the new populations of the availability of these new programs that expand coverage and will teach them how to apply for our programs. HRSA funding will protect our investment in outreach for these new expansions by harnessing technology solutions through eligibility modernization to make the redetermination process easy and seamless. The Department will require that all marketing and outreach activities include cultural and linguistic competence language as required in HRSA's *Administrative and National Policy Requirement*. Additionally, one of the medical home standards the Department is implementing for its public health insurance programs require that providers demonstrate cultural competence.

Marketing Plan for Expansion Populations. Because of our limited expertise in developing outreach strategies to some of the new expansion populations such as childless adults and individuals with disabilities, the Department proposes to hire a social marketing consultant, if awarded HRSA funding. This contractor will perform a needs assessment and research best practices of appropriate outreach efforts for the expansion populations throughout the term of this grant. The Department will utilize the consultant to create an effective and informed approach for the expansion populations to meet the Department's goal of enrolling all eligible people in our public health insurance programs. Over the last year, the Department has begun to focus much more on health outcomes for our clients, especially around obesity, smoking cessation, and prenatal care. We envision that the social marketing consultant would also advise the Department on the best methods to encourage clients to make healthy choices to improve their health outcomes.

During SFY 2009-10, the Department will modify current brochures, desk guides, posters and fliers to incorporate for the first two expansion populations to be implemented: CHP+ children and pregnant women to 250% of FPL and low-income parents to 100% of FPL. The marketing materials will be supplied and handed out at all enrollment fairs, conferences and other community events. The Department will utilize Public Service Announcements to help market the expansion programs. The plan combines local and statewide active collaborations, supports regional Family Health Coordinators collaborations with community-based organizations (CBOs), strategic marketing, trainings, material development and continuous evaluation. The plan will also identify new ways to communicate with these expansion populations such as through the use of cell phones or the Internet. In SFY 2010-2011 the Department will aggressively establish a marketing campaign focused on the expansion population for adults with disabilities (buy-in) up to 450% of FPL, through the use of the results established with the consultant in SFY 2009-2010. In SFY 2011-2012 the Department will continue all efforts established in SFY 2009-2010 and SFY 2010-2011. In SFY 2011-2012, a new marketing campaign will be developed for the expansion populations for childless adults to 100% of FPL, utilizing the results of the social marketing consultant and the needs assessment.

- 1. Hire a contractor to perform a needs assessment to research best practices in outreach to expansion populations, measured by a comprehensive outreach and marketing plan.
- 2. Execute the marketing plan in a phased approach based on implementation of HB 09-1293.

3. Design, produce and distribute new brochures, desk guides, posters and fliers for clients, providers, and community partners.

Expand Healthy Communities Outreach Model. Experience from the Department's various outreach models and strategies suggests that outreach efforts are most successful when they are performed in a local community by organizations that are trusted by those community residents, accessible and convenient to the targeted population and coordinated with other community programs and services. Healthy Communities represents a model that will deliver outreach services in a comprehensive and coordinated way to ensure that all members of the expansion populations eligible for Medicaid, CHP+ and the buy-in programs have coverage and access to needed health care services.

Over 50 Family Health Coordinators statewide will provide outreach to eligible but not enrolled (EBNE) children, pregnant women and the expansion populations for low-income parents or guardians up to 100% of FPL and CHP+ up to 250% of FPL for both the Family Medicaid and CHP+ programs. In SFY 2010-2011, the Department will expand Healthy Communities and add Adult Health Coordinators to incorporate the expanded population of adults with disabilities (buy-in) up to 450% of FPL. In SFY 2011-2012 the Department will further expand Healthy Communities to incorporate the final expansion population of childless adults up to 100% of FPL. This outreach will be achieved by developing working partnerships with previously mentioned community-based organizations and providers.

The Coordinators will assist families, adults with disabilities and childless adults and community-based organizations that work and support these populations. They will be responsible for outreaching to families, adults with disabilities and childless adults in regards to facilitating successful enrollment and promoting continued retention in the programs. They will ensure that applicants can find accessible and culturally sensitive assistance in their communities at a variety of sites. Most importantly, they will educate families, adults with disabilities and childless adults on program benefits and the importance of preventive care as well as promote access to a Medical Home. The Medical Homes approach empowers families, adults with disabilities and childless adults to assume responsibility for their health care.

1. Expand capacity of the Department's new Healthy Communities Outreach Program. Health Coordinators are located throughout the state and focus on all of the activities that must happen if a client is to obtain coverage and access health care services in appropriate settings. The "life cycle of the client" includes outreach and application assistance; the eligibility determination process; access to health care services; provider recruitment and retention; linking clients to a medical home; and the retention of clients if they continue to be eligible.

Expand Enrollment Fair Mini-Grant Program. The Department relies on its community partners and stakeholders to assist families in the application process. The enrollment fair has proven to be an effective and efficient method to enroll eligible children in Medicaid and CHP+ and to provide outreach to those families that have recently lost medical coverage.

The Department plans to continue offering this mini-grant program opportunity to community service partners that serve eligible, but not enrolled children and expand the grant program to partners who serve adults with disabilities and childless adults. With a dedicated FTE, the Department will be able to conduct a bi-annual Enrollment Fair Mini-Grant Program. The Enrollment Fair Mini-Grant Program will be expanded to assist providers that serve all of the expansion populations by establishing new collaborative relationships among entities that have a focus on increasing enrollment for these populations. Through these enrollment efforts, partners will educate local communities, including individuals who have become recently uninsured, about the availability of preventive, chronic and sick care provided by enrollment in Medicaid, CHP+ and the buy-in programs.

1. Sponsor "Enrollment Fair Mini-Grant Enrollment Fairs" to community-based organizations (CBOs) targeted to expansion populations measured by number of enrollments.

Reimbursement to Community-Based Organizations for Application Assistance. In SYF 2009-2010, the Department will implement fee-based (\$50 per application) application assistance for Certified Application Assistance Sites (CAAS) supporting expansion populations through the use of a web-based tool developed to track successful enrollment into the expanded populations of individuals with disabilities (buy-in) up to 450% of FPL in SFY 2010-11; and childless adults to 100% of FPL in SFY 2011-12. Funding for this activity is planned to cover about 20 percent of the new applications submitted; the number of new enrollments generated from this incentive payment will dictate the feasibility of continuing the practice in the future.

Conduct Statewide Training Conferences. The Department plans to host eight conferences each year of the grant. Four of the conferences each year will be specific to those community partners hosting enrollment fairs throughout Colorado's communities. These conferences will provide training on conducting enrollment fairs, provide technical assistance and establish best practices for continued success.

The additional four conferences per year will be regional conferences situated throughout Colorado to provide trainings on federal and state rules and regulations, outreach techniques and tools, best practices, networking and technical assistance to community partners providing services to the new expansion populations. Targeted community partners will include community-based organizations, county departments of human/social services, medical assistance sites, presumptive eligibility sites, providers and other identified community partners. These conferences will provide specific support and education to community partners that provide services or assistance to the new expansion populations.

1. Provide statewide enrollment and training conferences to share policy and program information as well "best practices" and "lessons learned" on outreach approaches that are effective and increase the number of people who have health coverage.

2. Eligibility Modernization: Streamlining the Application Process

Background. Please refer to the Needs Assessment Section, Barriers with Infrastructure of Coverage, for background information on the need for this project.

Project Design, Scope and Project Activities. To achieve our goal of enrolling these new populations, we need to make the appropriate investments in technology and in our infrastructure to increase our operational capacity to accommodate these 150,000 new enrollees. A 2009 Commonwealth Fund Study found that the citizenship and identity requirements under the Deficit Reduction Act (DRA) make getting and keeping children and families covered more difficult. The new requirements increased the complexity, administrative burden, and costs of enrollment and renewal in the states studies, and in some cases, the rules even comprised other processes. A "best practice" identified in Colorado's Eligibility Modernization Report is for the state to create interfaces to other State and Federal systems to ease data exchange and reduce manual labor efforts (10% reduction in application processing times is projected). The Center on Budget and Policy Priorities reported that 78% of children and 43% of adults ages 18-64 living in Colorado were born here; facilitating data matches with vital statistics data could simplify citizenship verification for the majority of applicants. The Department is requesting HRSA funding to establish interfaces between the Department's computerized eligibility system, the Colorado Benefits Management System (CBMS) and existing Federal, State and other program databases to ease the administrative burdens.

HRSA funding can also enable us to expand the availability of web-based online applications for these new expansion populations and meet the increased demand on the entire eligibility determination process. Work is already underway by our CBMS vendor, Deloitte, to develop and implement a web-based online application for the current Medicaid and CHP+ clients that should be completed in early 2010. Research indicates that a growing number of low-income residents have access to computers and the Internet. Many states have experienced great success in developing online tools. In Massachusetts, approximately 50% of all applications are submitted online and the average time required to complete a Medicaid application dropped by 55%, from 20 minutes to 9 minutes.

The Department also proposes to use HRSA funding to develop statewide automated enrollment systems for the new expansion populations that result in "Express Lane Eligibility" as well as administrative or ex parte renewals. Under the Children's Health Insurance Program Reauthorization Act (CHIPRA), states are encouraged to implement Express Lane Eligibility or automated enrollment that helps minimize the administrative burdens of the enrollment and renewal process for applicants, while also improving efficiencies and providing greater accountability. States that have implemented Express Lane Eligibility report that it is an effective means to increase enrollment while lowering ongoing operating costs and reducing erroneous eligibility determinations.

- 1. SFY 2009-10: Design, develop and establish an interface between CBMS and the Colorado Department of Public Health and Environment to verify birth certificates and records for applicants and clients for expansion populations.
- 2. SFY 2009-10 and SFY 2010-11: Design, develop and establish an interface between CBMS and the Colorado Department of Revenue, Division of Motor Vehicles to verify identity for applicants and clients for expansion populations.

- 3. SFY 2009-10: Design and develop a real-time system verification system with the Social Security Administration to meet citizenship verification requirements for expansion populations.
- 4. SFY 2009-10: Design, develop, and implement changes to CBMS that will permit the administrative verification of income through existing wage databases including the Colorado Department of Labor and Employment (DOLE) as well as the Income and Eligibility Verification System (IEVS) for expansion populations.
- 5. SFY 2009-11: Design, develop and implement changes to CBMS in coordination with Free and Reduced Lunch Program and design, develop and implement changes to CBMS in coordination with the Department of Revenue (income tax records) to implement automated enrollment processes or Express Lane Eligibility for expansion populations.
- 6. SFY 2010-11: Design, develop, and implement changes into CBMS to accommodate passive re-enrollment for expansion populations.
- 7. SFY 2009-10: Design, develop, and implement changes into CBMS to allow expansion populations to apply for health care coverage online.

3. Childless Adults and Buy-in for Individuals with Disabilities Implementation

Project Design, Scope and Project Activities. HB 09-1293 gave the Department limited funding in SYF 2010-11 to begin work in setting actuarial sound provider reimbursement rates for the childless adult and individuals with disabilities buy-in expansions populations. The Department prepared the fiscal note for HB 09-1293 almost six months ago based on its knowledge of the requirements of adding these expansion populations. However, upon further research, the Department determined that it needed additional funding beginning in SFY 2009-10 to hire subject matter experts (consultants) to assist with the 1115 waiver applications as well as the benefit design for both of these programs to meet the implementation schedule outlined in the legislation. Additionally, SHAP funding would allow the Department to engage stakeholders in this process for the purposes of optimizing the development and implementation of the new benefits for these expansion populations. The Department actively seeks the participation of all key stakeholders for any new initiative. An inclusive consensus-building process is transparent and gives stakeholders real input. Specifically, the contractor's scope of work would include the following activities:

- Conduct an actuarial study and fiscal analysis to develop possible program models that could be implemented to meet the needs of the target population;
- Develop potential program designs, including models for premium structures, costsharing, income and asset limitations, etc., and program designs that make the programs as cost-effective as possible;
- Collect stakeholder input and feedback about possible program models and premium structures (as a piece of the larger collection of input and feedback about the overall program);
- Analyze programmatic limitations and benefits of these program models; and
- Develop conclusions about budget impacts of these models.

In addition, the Department assumes that it would be necessary to submit a State Plan Amendment, as well as receive a Federal waiver to establish the adult expansion. The

Department assumes that the new adult expansion would require an 1115 demonstration waiver from the federal Centers for Medicare and Medicaid Services (CMS). Proposals are subject to CMS, Office of Management and Budget (OMB), and Department of Health and Human Services (HHS) approval, and may be subject to additional requirements such as site visits before implementation. CMS does not have a specific timeframe to approve, deny, or request additional information on the proposal. Additionally, CMS usually develops terms and conditions that outline the operation of the demonstration project when it is approved.

Finally, HRSA grant funds are needed to expand the Department's effort to recruit and retain new providers to ensure that adequate network capacity exists for newly enrolled public insurance clients. The Department needs to develop a targeted approach to provider recruitment for these expansion populations to address the inadequate supply of primary care and specialty providers who see adult patients and patients with disabilities and complex medical needs. The Department has had success in recruiting pediatricians that will see Medicaid and CHP+ children, but needs to bolster the number of providers participating in the program who will see adult clients and increase the number of Medicaid slots for new patients.

- 1. SFY 2009-10: Hire a consultant to assist with rigorous research of best practice models in other states and recommendations for Colorado.
- 2. SFY 2009-10 and Ongoing: Contract with Peregrine Management Corporation to regularly survey all Colorado providers on their participation in public insurance programs and panel status.
- 3. SFY 2009-10 and Ongoing: Contract with consultant with health background to recruit primary care and specialty providers that see adults and individuals with disabilities and complex medical needs.
- 4. SFY 2009-10 and Ongoing: Contract with consultant to develop and disseminate outreach materials to assist with provider engagement, enrollment, and training.

4. CHP+ At Work Premium Assistance

Background. Premium assistance is a promising strategy for providing coverage to children in low-income families with access to employer-provided coverage. Through federal authority, public health insurance programs for children can help any eligible persons pay the premiums required to enroll in any private health insurance that is available to them. This approach is particularly cost-effective for employment-based insurance because employers already pay a sizable share of the total premium. CHIPRA includes new opportunities for States to offer premium assistance programs, including language requiring employers to provide written notices to their employees, informing them of the potential opportunities for premium assistance.

Project Design, Scope and Project Activities. In September 2006, the Federal government authorized the CHP+ program to provide premium assistance to families with CHP+ eligible children who enroll in their employer-sponsored plan. The CHP+ at Work program pays a direct subsidy to families who enroll in a guardians' employer-sponsored health insurance plan on a per eligible CHP+ child per month basis. The current program design allows for a CHP+ subsidy not to exceed \$100 per eligible child per month.

This program does not require any change to the employer's insurance enrollment process. It is a direct subsidy to the family. Through the program, the family sends in a complete application to the CHP+ at Work program, including the employer-sponsored health plan the family is choosing. The CHP+ at Work program processes the application and determines eligibility for CHP+. Once determined eligible, the family completes the health plan enrollment process through their employer in the usual manner. The CHP+ at Work program verifies employment and employer-sponsored insurance enrollment with the employer.

While the CHP+ at Work program is designed to target medium to large employer groups, the CHP+ program piloted the CHP+ at Work with one employer - Denver Health and Hospital Authority. The pilot began in October 2006 with an employer-sponsored enrollment effective date of January 1, 2007 that covers more than 60 families. Due to the success of the pilot, the CHP+ at Work program would like to expand the program and make it available statewide. This change would expand the program to include all employers of families with eligible children, not just the pilot employer. Under HB 09-1293, more children will be eligible for the program as a result of the population expansions.

Colorado has plans to expand its current CHP+ at Work program statewide; however, system enhancements necessary to do this and a lack of resources have delayed implementation. Support from this grant would allow CHP+ at Work to be included in Colorado's eligibility determination system (CBMS) thus supporting efforts to expand the program to include all employers of families with eligible children. Once in CBMS, families eligible for CHP+ at Work may simply fill out the joint application to apply, and a county or Medical Assistance (MA) site can enter the application into CBMS to determine eligibility. Support from this grant would also allow the Department to engage a vendor to assist with employer group recruitment, employer group customer service, assistance with employer group open enrollments, development and operations of a quality assurance and program evaluation plan.

- SFY 2009-10: Design, develop and implement changes into CBMS to allow CHP+ at Work eligibility to be determined within CBMS.
- SFY 20010-11: Hire a contractor to actively recruit employers to participate in the CHP+ at Work expansion program.

5. Health Access Pueblo: Community Multi-Share Expansion

Project Design, Scope and Project Activities. Health Access Pueblo (HAP) is a community-based non-profit organization created to provide high quality, affordable, basic health coverage for the uninsured who work for employers based in Pueblo County modeled after Access Health in Muskegon, Michigan. Governor Ritter signed into law House Bill 07-1022 that authorized the creation of HAP. To finance the program, enrolled employers contribute one-third of the premiums, employees contribute another third, and the final third of premium costs is shared by the community. This "third share" is provided primarily by community benefit funds from the hospitals and from foundation grants. HAP became available in August 2008, but only has 40 members; however, those members are already participating in smoking cessation and wellness classes and have completed their initial health risk assessments. Low numbers are enrolled because of the unavailability of funds to mount an aggressive outreach and marketing plan to

businesses in Pueblo County. Without the HRSA grant funding, we lose an opportunity to reduce the number of people lacking access to affordable health care coverage and access to a medical home in Pueblo County.

The purpose of HAP is to provide high quality health care coverage to qualified persons who work for firms based in Pueblo County. The goal for this proposed project is to expand access to health care coverage for the uninsured in Pueblo County by increasing the number of persons enrolled in HAP to 1,000 members by 2012. This enrollment figure will provide a rationale to the State for extending HAP's operating authority and will provide sufficient economies of scale to ensure HAP's financial sustainability.

- 1. Search for and hire Sales Executive.
- 2. Develop and execute Marketing and Advertising Plan.
- 3. Research and purchase IT and phone system commensurate with marketing plan needs.

6. San Luis Valley: Three-Share Community Start-Up

Project Design, Scope and Project Activities. House Bill 09-1252 was enacted into law authorizing the creation of a three-share community start-up pilot program in the San Luis Valley (SLV Health Access Program) to address the healthcare needs of the uninsured population. This pilot will be operated under the oversight of the San Luis Valley County Commissioners Association; an association comprised of the 18 County Commissioners representing the 6 geographically confined rural counties known as the San Luis Valley. The goal of the SLV Health Access Program is to provide a health coverage program aimed at the working uninsured in employer groups where the median hourly wage is \$15.00 per hour or less and the employer group currently provides no health insurance. The program would enable an employersponsored health access plan to utilize contributions from the employer, the covered employee and the community (a three-share program). HRSA grant funding would be used to fund the 'third share" of this multi-share approach to coverage. The objective is to create access to services using currently untapped private dollars supplemented with SHAP grant funds during the early years to cover the third leg (the community portion) of the SLV Health Access Program. The program would move towards sustainability without the need for grants or other sources of governmental funding. Over 5,000 individuals not currently covered would be eligible for the program and the goal is to enroll 1,000 uninsured workers by year five of the HRSA grant. Start-up activities include:

- 1. Set pricing for benefit design.
- 2. Develop employer contracts and provider contracts.
- 3. Develop marketing materials to employers and employees.
- 4. Configure system to manage benefit designs, employer billing and provider payments.
- 5. Implement marketing campaign to target groups.
- 6. Begin enrolling groups.
- 7. Develop reporting package.

Weld County: Evidence-Based Benefit Design Pilot

Project Design, Scope and Project Activities. Senate Bill 08-217, Centennial Care Choices directed the State to solicit input from private insurance carriers on creative and innovative ways to offer affordable, "value" benefit plans to the state's currently uninsured residents. Over a period of eight months, state agencies worked with Colorado health insurance carriers to come up with affordable plans that provide at least a basic level of credible coverage to the state's uninsured. One of the health insurance carriers' proposals included the development of a prioritized benefit design tool. With HRSA funding, the State intends to develop a transparent and evidence-based benefit design tool, and begin offering this affordable and high-value benefit package to a targeted population of uninsured Coloradans through a pilot program in Weld County in northeastern Colorado.

Once the benefit design tool has been developed, it is anticipated that the tool can be utilized to create a private health insurance product that is affordable and attractive to currently uninsured individuals and businesses not already offering employer-sponsored insurance. Additionally, this tool would contribute significantly to the development of publicly-subsidized and/or expansion population benefit packages, ensuring that every dollar invested in public coverage programs is buying the highest value possible instead of paying fees for services that may or may not be effective. Focusing on the most effective use of public and private investments in health coverage will allow existing and future resources to go farther, utilizing the same amount of money to cover more people without compromising quality or health outcomes.

- 1. In a transparent and publicly accountable manner, create a high-value, evidence-based benefit design tool that is viable for use in a private insurance product and that could be adapted for use in public programs such as a Medicaid expansion populations.
- 2. Carry out strategies to encourage maximum involvement and buy-in from health care providers in the pilot area.
- 3. Engage consumers in the pilot area in the development of the benefit design tool, as well as educate them about evidence-based, cost-effective care.
- 4. Provide public education support for private health plans offering products based on this novel concept in order to ensure and sustain sufficient enrollment.

Evaluation Plan

The following Healthy People 2010 goals will be advanced, with support from HRSA, by improving and expanding public health insurance in Colorado:

HP 2010 Goal	Description
1-1	Increase the proportion of persons with health insurance
1-5	Increase the proportion of persons with a usual primary care provider
1-6	Reduce the proportion of families that experience difficulties or delays in obtaining health care or do not receive needed care for one or more family members;
1-9	Reduce hospitalization rates for pediatric asthma and uncontrolled diabetes
1-15	Increase the proportion of persons with long-term care needs that have access to the continuum of long term care services

6-1	Include in the core of all relevant Healthy People 2010 surveillance instruments a standardized set of questions that identify "people with disabilities
6-6	Increase the proportion of adults with disabilities reporting satisfaction with life
14-24	Increase the proportion of young children and adolescents who receive all vaccines that have been recommended for universal administration for at least five years
15-12	Reduce hospital emergency department visits caused by injuries
21-10	Increase proportion of children and adults who use the oral health care system each year

Healthy People 2010 goals *1-1* and *1-5* were chosen to measure the activities that increase the number of people who have health care coverage and as a result access to primary care. *1-6*, *1-15* and *15-12* were chosen to measure how well individuals are able to use the health care system. Many factors influence this measure such as an individual's understanding of their health insurance benefits, ability to navigate the health care system and affordability of co-pays and other health care costs. Program outputs will be monitored carefully to understand which interventions are associated with improvements in these measures after five years. *1-9* was chosen because it is a long term outcome measure of having health insurance and accessing health care appropriately. It is also a proxy measure for increasing cost effectiveness in

health care systems. 6-1 was chosen to allow the Department to measure risk behaviors, outcomes and population health for people with disabilities using the state supported Behavioral Risk Factor Surveillance System. Currently, there is not a systematic way to identify adults with disabilities on surveys in Colorado.

6-6 was chosen for the new population of adults with disabilities who will be allowed to buy into the Medicaid program. The result will be an increase in the amount of money an adult with disabilities is allowed to earn through employment without losing their health insurance. The ability to work without losing one's health insurance is hypothesized to directly affect a person's quality of and satisfaction with life.

14-24 was chosen to measure improvements in Colorado's immunization rates as a result of having health insurance and accessing primary care in children on public health insurance. 21-10 was chosen to measure access to dental health care by both children and adults. Access to dental care is an important part of overall health and having a medical home.

To address the chosen Health People 2010 goals the Department is 1) Modernizing the public insurance eligibility process to make it easier to use, more timely and satisfactory to our clients, as well as increase the ability to handle a projected increase in enrollment due to the expansion of eligible populations; 2) Offering a buy in program for adults with disabilities who are on Medicaid, desire to work and have not been able to do so because of the current asset limitations. They will be able to work without jeopardizing their health insurance; 3) Offering public insurance to childless adults up to 100% of the Federal Poverty Level (FPL). In addition, the Department is expanding a pilot program statewide that offers premium assistance to families with CHP+ eligible children so that they can receive employer-sponsored coverage.

All expansion programs and projects for which we are requesting funding are supported by education and outreach to eligible members, community partners and providers under this grant proposal. Education and outreach activities are listed in the work plan and affect each of the chosen objectives listed below. Each expansion program has a list of activities for which they have identified measureable outputs. For each measureable output, annual benchmarks have been set that will help them monitor the program's progress towards achieving the following five year objectives. Colorado believes the following five year objectives will improve the health people 2010 goals listed above.

Program Specific HRSA Objectives

To improve the enrollment process, the Department will:

- 1. Increase the timeliness of enrollment (including reenrollment) to < 45 days for Medicaid and CHP+ and < 60 days for long term care insurance from the current, > 45 days and > 60 days respectively, starting in year one and achieve these goals by year five.
- 2. Ensure that 85% of county case files for publically insured Members have been verified by CBMS for the needed eligibility documents from baseline by year five.
- 3. Increase satisfaction with the health insurance enrollment process in all newly enrolled clients from 10% to 50% by year five.

To ensure that Members with disabilities can continue to work when they so desire the Department will:

- 1. Develop a set of standardized questions that will identify people with disabilities during data collection by year one.
- 2. Change the Medicaid waiver so that 85% of Members with disabilities (who desire and are able to gain employment) may do so by year five.
- 3. Increase clients with disabilities satisfaction with life to 85% by year five.

In an effort to improve the health of our childless adult population the Department will:

- 1. Enroll at least 50% of eligible childless adults in public health insurance by year five after development of a benefits package.
- 2. Thirty percent of childless adults on Medicaid will access primary health care and dental health services at least one time a year by year five.

HRSA Objectives for All Expansion Programs

- 1. Ensure a 70% enrollment in new expansion Medicaid and CHP+ Members and 50% in childless adult populations by year five.
- 2. Increase the proportion of clients over 19 years old with a primary care provider to 80% by year five.
- 3. Increase the proportion of clients under 19 years old with a Medical Home from 55% to 80% by year five.
- 4. Increase the penetration of enrolled Medicaid clients who have a primary care provider from zero to 80% by year five.
- 5. Increase awareness of Medicaid and CHP+ benefits from baseline to 95% as evidenced by clients receiving age appropriate preventive health care, including dental, by year five.
- 6. Increase the number of children with age appropriate immunizations rates from 55% to 80% by year five.

7. Increase the number of complete public insurance applications generated by community-based organizations in Colorado from 15% to 85% by year five.

To measure the program outputs, HRSA objectives and Healthy People 2010 goals, the Department will hire an external evaluator to develop and implement an evaluation plan that describes how program outputs, HRSA objectives and Healthy People 2010 goals will be measured, including: how each measure will be defined for measurement, data sources appropriate to measure the output, objective or goal, which population each measurement will be measured in and how samples from populations will be chosen. An annual work plan for evaluation will be created and followed. Barriers to meeting outputs, objectives and goals will be documented quarterly and reported in each HRSA annual report.

The external evaluator will have expertise in feasibility and impact evaluation of public insurance programs. S/He will have expertise in data analysis and survey development. Contract monitoring will be provided by the Department.

During the development of the evaluation plan, each program will work with the evaluator, or evaluation team, to define how each objective will be defined and measured. A statistically appropriate sample from each expansion population will be identified for data collection and measurement.

Data sources to measure the Healthy People 2010 goals and HRSA objectives will be identified from the Medicaid Medical Information System (MMIS), the Colorado Benefits Management System (CBMS), LEIF (the actuary holding the encounter data for the CHP+ program), and the Colorado Department of Labor and Statistics. A satisfaction survey will be developed for the Medicaid disabled population and be administered by the evaluator or a sub contractor for survey administration. Data sources to measure work plan outputs will be identified by the relevant program with the evaluator's assistance. Additional data will be available via an Evaluation Team from the University of Colorado Denver (funded by The Colorado Trust) working along with the Department to conduct a three-year evaluation of community-based outreach programs and their impact on enrollment, retention and use of Colorado's public health insurance programs. This will allow evaluation of providing outreach and application assistance activities in community-based settings that traditionally have not provided these services. The evaluation will assess program-level impact indicators by linking application assistance data (grantees will submit their identifiable client information directly to the Department) with secondary data from CBMS and MMIS. Within the MMIS, the Department will be able to identify the expansion groups by using Program Aid code. This will not only allow us to follow the "life cycle" of the client through the application and renewal processes, but will also allow us to look at benefits utilized by the expansion population in comparison with the current population. We anticipate the outcomes to include increased enrollment, retention, and utilization for children in Colorado and a more comprehensive understanding of successful outreach and application assistance strategies for non-traditional, community-based settings.

Healthy People 2010 goals will be measured during year one, year three and again in year five. Data sources referenced on the Healthy People 2010 web site http://www.healthypeople.gov/ will be used. HRSA objectives will be measured annually using the data source and population

identified in the evaluation plan. Work plan outputs will be measured quarterly. By comparing program outputs to the stated benchmarks quarterly, each program will be able to identify barriers to meeting HRSA objectives and make program changes quickly.

Evaluation Timeline

<u>Evaluation 1 inferine</u>							
Year 1	Year 2	Year 3	Year 4	Year 5			
 Hire external evaluator Develop evaluation work plan Define measures Identify data sources to use for measurement Develop quality of life survey for Medicaid disability population Begin development of standardized questions for adults with disabilities and establish baseline for all measures Analyze HRSA objectives 	 Review quarterly work plan outputs Document barriers to achieving programmatic benchmarks Analyze HRSA objectives Prepare first annual report for HRSA 	 Analyze Healthy People 2010 goals Analyze HRSA objectives Review quarterly work plan outputs Document barriers to achieving programmatic benchmarks Prepare second annual report for HRSA including comparisons with baseline values 	 Review quarterly work plan outputs Document barriers to achieving programmatic benchmarks Analyze HRSA objectives Prepare third annual report for HRSA 	 Analyze health people 2010 goals Analyze HRSA objectives Review quarterly work plan outputs Document barriers to achieving programmatic benchmarks Prepare second annual report for HRSA including trend analysis of HRSA objectives and healthy people 2010 goals. 			

WORK PLAN

The Department's detailed **Work Plan** that is submitted as Attachment 3 offers a description and timetable for tasks to be conducted pre-implementation and post-implementation. It also identifies those parties responsible for completing project tasks as well as the outcomes and performance measures for those outcomes where appropriate. The Department's **Budget Narrative** correlates the five year funding plan to specific projects and timelines.

Management, Accounting and Governance Structure. The Department has a multi-level organizational structure that is well established and qualified to manage CO-CHAMP. Governor Ritter appointed Joan Henneberry as the Executive Director for the Department in January 2007. Ms. Henneberry consults with an Executive Committee composed of high level managers including directors of the Medicaid and CHP+ Program, Human Resources, Administration and Operations, Project Management, Budget and Finance and Client and Community Relations. Management decisions are also made with input from the Leadership Team consisting of Division Directors and Managers serving in key positions. Members of this team bring a wide range of knowledge critical to the success of this project including expertise in information technology, federal financing, business analysis, client services and accounting.

The staff administering CO-CHAMP includes several of these high level managers. Key back-up staff from both program and administrative divisions will handle the workload and oversight required by a project of this scope. Management is committed to policies and mechanisms that are tied to expected outcomes and to continuously identifying and implementing administrative efficiencies. The Deputy Director for the Office of Client and community Relations and her staff will be responsible for preparing and submitting all grant reports to HRSA timely and accurately.

During the process of putting the grant application together, the Department convened a group of other state agencies, safety net providers and advocacy organizations. We will select an advisory committee from this group of participating stakeholders to assure that activity and reporting time lines are being met and that any delays to the implementation of this project will be resolved.

The Department maintains superior budget and accounting processes to manage the HRSA grant. Further, the Department has more than adequate management of budget and audit controls for direct expenditures and subcontractors. The Accounting Section at the Department has 13 employees. The managerial and supervisory staff, comprised of five of the 13 employees, has extensive State governmental accounting experience, ranging from a low of 10 years to a high of 21 years. The Accounting Section tracks and records a total annual Departmental budget approaching \$4 billion dollars when all sources of funding are considered. The accounting entries are made by using a fully computerized and robust system called Colorado Financial Reporting System (COFRS) that has been operational for several years. COFRS is used for all state agencies and functions well with no operational or mechanical problems.

All grants that the Department receives have a unique Grant Budget Line Code and Appropriation code created and assigned in order to identify and isolate the expenditures to each grant. The expenditures for each grant are recorded in COFRS. Each grant is also assigned a unique appropriation code. The appropriation can only be set up in the amount of the grant award which controls the amount that can be spent or amounts that can be committed against the appropriation. These appropriation codes are approved by the Office of the State Controller and must be accompanied by a copy of the award and a copy of the check amount is usually included for supporting documentation. Any contract that is encumbered against the appropriation cannot be more than the established appropriated amount. Program staff monitors and review contracts associated with the grant. Accounting and program staff assigned to the grant meet on a monthly basis to review grant expenditures recorded in the COFRS system. There are also monthly financial reports generated by COFRS for each grant, examples are "Grant Revenues and Obligations by Month and Year-to-Date" and "Summary Trial Balance by Grant within Agency". These expenditures are reviewed for reasonableness and are compared to the budgeted amount for each grant. When Program staff submit their invoices for payment to accounting they are verifying that they have received the services provided by the contract by signing the receiving report authorizing payment to the vendor. These expenditures are reviewed again when the financial reports are submitted to the grantor.

RESOLUTION OF CHALLENGES

The Department is confident that it has the sufficient expertise and resources to effectively manage the SHAP grant. We recognize that our ability to manage a grant of this size will impact CO-CHAMP's success and our reputation which in turn may determine whether the Department

receives grants in the future. Unexpected events can sometimes divert resources from one project to another that result in tasks not being completed on time. Losing dedicated resources to another higher priority project can alter the implementation timeline of projects. All of the Deputy Directors in the Department have dedicated resources to manage legislation and other major Department initiatives. This grant proposal includes a request for funding for one FTE, General Professional VI (high level manager), Grant Administrator for CO-CHAMP. We will mitigate the challenges that are associated with the management of the grant as follows:

- Monitor: We will set up a plan to continuously monitor our CO-CHAMP project. This plan will list all the goals that we said we would achieve in the grant, and list the step that must occur to demonstrate that we achieved the goals. We will look at this and determine how successful we have been in achieving the goals on a weekly basis.
- Audit Expenses: We will make sure that multiple people look at all expenses and that they are familiar with the grant. We do not want to have an unallowable expenditure because it could significantly impact any future funding received from HRSA.
- Calendar. We will set up a calendar of all the required reports (fiscal and programmatic) that shows the deadlines for submittal and who will complete these.

EVALUATION AND TECHNICAL SUPPORT CAPACITY

A substantial amount of the CO-CHAMP requested funding involves implementing changes in CBMS and MMIS. In April of 2009, the State transitioned the operations and maintenance of CBMS to a new vendor, Deloitte Consulting LLP. Deloitte has performed exceptionally well. We are working closely with their staff and they have shared their experiences in other states on some of the projects we are proposing in the grant proposal. They are responsive to our requests and have deployed additional resources to the new projects on which they are working. In addition, the State's Office of Information Technology recently hired an Interim CBMS Director that will provide leadership and accountability with respect to CBMS. Please see the Biographical information for other relevant information on staff qualifications.

ORGANIZATIONAL INFORMATION

As mentioned throughout the proposal, the Department will assume responsibility for the implementation of the CO-CHAMP projects and management of the grant. Information on our capacity and ability to manage complex projects is well demonstrated. The agencies, community-based organizations and other community partners were mentioned previously in the grant. We are happy to provide any additional information upon request.

Epilogue: Dateline: June 2, 2013, Denver, CO. Governor Bill Ritter commemorated the five year anniversary of the signing of HB 09-1293, the Healthcare Affordability Act, by announcing that the State had met its target goal of insuring 150,000 more Coloradans through the program expansions created through the passage of the legislation. The Governor thanked the many stakeholders, community partners, providers and State staff that contributed to the success of reducing the number of people without health coverage. The Governor also took the opportunity to acknowledge the Health Resources and Services Administration and its State Health Access Program noting that much of the work could not have been accomplished without their funding and support.

Budget Narrative

Colorado House Bill 09-1293 (<u>HB 09-1293</u>) authorizes coverage expansions to more than 150,000 people: (1) CHP+ children and pregnant women up to 250% FLP; (2) low-income parents and guardians up to 100% FPL; (3) childless adults up to 100% FPL; and (4) buy-in for individuals with disabilities up to 450% FPL. Three proposed projects relate directly to these expansion populations.

1. Maximizing Outreach, Retention and Enrollment ("MORE"): The Department proposes to use HRSA SHAP funding to design, develop, and implement an outreach plan for new expansion populations.

Description	Year 1	Year 2	Year 3	Year 4	Year 5
Needs Assessment Contractor	\$100,000	\$0	\$0	\$0	\$0
Enrollment Fairs and Application Assistance	\$690,000	\$1,150,000	\$850,000	\$1,045,000	\$795,000
CBO Application Assistance	\$0	\$0	\$300,000	\$300,000	\$300,000
Client Application Tracking Tool	\$0	\$150,000	\$0	\$0	\$0
Enrollment Conferences and Regional Trainings	\$96,000	\$96,000	\$96,000	\$96,000	\$76,800
Health Coordinators	\$0	\$300,000	\$500,000	\$500,000	\$500,000
Equipment, Overhead and Travel for Health Coordinators	\$0	\$50,000	\$100,000	\$100,000	\$100,000
Social Marketing Consultant	\$0	\$90,000	\$50,000	\$45,000	\$5,000
Design, Develop and Print of Marketing Materials	\$0	\$70,000	\$95,000	\$95,000	\$75,000
Total Project Cost	\$886,000	\$1,906,000	\$1,991,000	\$2,181,000	\$1,851,800

Needs Assessment Contractor

- Department requires a contractor to perform systematic process to acquire an accurate, thorough picture of the strengths and weaknesses of "best practices" and "lessons learned" from other states to improve outreach methods for population expansions.
- Contractor will collect and analyze information about outreach and submit recommendations and a plan for outreach. The funding request is 100,000 for year one.

Enrollment Fairs and Application Assistance

- The enrollment fair has proven to be an effective and efficient method to enroll eligible children in Medicaid and CHP+.
- During each of the 5 years of the grant period, the Department will offer enrollment fair mini-grant opportunities to community-based organizations (CBOs) that serve expansion populations. It is anticipated that 40 grants will be award per year over a five year period. Amounts for each year are based on anticipated dates for new expansion populations.

Community-Based Organizations Application Assistance Funding

• CBOs form the foundation of our outreach strategy – the "trusted hand" model.

- CBOs are often non-profits and lack sufficient resources. The Department plans to reimburse CBOs \$50 for every successful enrollment as way of supporting CBOs and as a way to increase the number of CBO's providing application assistance.
- Department needs to measure impact of reimbursement and needs a tool that can accurately track positive enrollment and the CBOs that assisted clients in the application process.

Enrollment Conferences

- CBOs and other community partners need latest program and policy information.
- The Department will sponsor two enrollment conferences and six regional conferences for the first 4 years of the grant and two enrollment conferences and five regional conferences in year five of the grant to train on eligibility policy changes, to share best practices and lessons learned on outreach strategies. (Assumptions: \$12,000 average cost per event)

Expand Capacity of the Healthy Communities Outreach Program

• The Healthy Communities Outreach Program will require additional resources as a result of the coverage expansions to provide outreach, in-reach and support to community partners and providers. Assumptions: Year 2 with 6 FTE @ \$50,000/FTE plus \$50,000 for equipment (laptops, cell phones) overhead expenses and travel costs for Health Coordinators. For each of the remaining 3 grant years with 10 FTE @ \$50,000/FTE plus \$100,000 for equipment (laptops, cell phones, overhead expenses and travel costs for Health Coordinators for each year.

Marketing

- Social marketing campaign and expertise is needed to conduct effective outreach in additional to brochures, desk guides, posters and fliers.
- Assumptions: Social Marketing Consultant \$90,000 Year 2 and gradually phased out during years 3-5; Review, design, production and translation of materials (\$25,000), advertising (\$20,000), printing (\$12,000) and promotion giveaways (\$18,000) for Year 2 of grant. Years 3 5 of grant will vary marketing costs based on implementation dates for expansion populations.
- 2. Eligibility Modernization: Streamlining the Application Process: The Department proposes to use SHAP funding to streamline the application process by replacing paper documentation with electronic data where possible; develop web-based services for clients; and create interfaces to other State and Federal systems to ease data exchange and make overall application process more efficient and effective. These updates are necessary to support the increased caseload resulting from expanding eligibility; efficiencies will also benefit currently eligible populations.

Citizenship and Identity Verification Interfaces for Expansion Populations

• Commonwealth Fund study of 7 states (January 2009) found that the citizenship and identity requirements under the Deficit Reduction Act (DRA) make getting and keeping children and families' coverage more difficult. The new requirements increased the complexity, administrative burden, and costs of enrollment and renewal in the states studies, and in some cases, the rules even comprised other processes.

- A "best practice" identified in Colorado's Eligibility Modernization Report is for the state to create interfaces to other state and federal systems to ease data exchange and reduce manual labor efforts (10% reduction in application processing times is projected).
- The Center on Budget and Policy Priorities reported that 78% of children and 43% of adults ages 18-64 were born in Colorado: facilitating data matches with vital statistics data could simplify citizenship verification for the majority of applicants.
- Families report the costs and administrative burdens to acquire birth certificates prevent them completing Medicaid applications.

Automation of Vital Statistics Retrieval	Year 1	Year 2	Year 3	Year 4	Year 5
CDPHE Implementation/Maintenance	\$55,000	\$20,000	\$20,000	\$20,000	\$20,000
CBMS Costs (\$105/hour)					_
Requirements (240 Hours)	\$25,200	\$0	\$0	\$0	\$0
Design (480 Hours)	\$50,400	\$0	\$0	\$0	\$0
Application Changes (1,000 Hours)	\$105,000	\$0	\$0	\$0	\$0
Decision Table Changes (720 Hours)	\$75,600	\$0	\$0	\$0	\$0
Acceptance Test (860 Hours)	\$90,300	\$0	\$0	\$0	\$0
Implementation (80 Hours)	\$8,400	\$0	\$0	\$0	\$0
Total CBMS Costs	\$354,900	\$0	\$0	\$0	\$0
Total Project Costs	\$409,900	\$20,000	\$20,000	\$20,000	\$20,000

Budget Justification for Automation of Vital Statistics Retrieval: Vital Statistics is requesting funding for one staff person (Other Agency Database Contract Manager described in Attachment 4 "Job Descriptions for Key Personnel."). In addition, funding is needed for the start-up cost of linking with the national vital records database to verify out-of-state born citizens (\$50,000), required software (\$5,000) and equipment maintenance (\$20,000 per year). In addition, the Department would need funding to make necessary modifications in CBMS, which would document how an applicant's citizenship or birth certificate was verified. The CBMS changes include importing client data from the vital statistics interface into a temporary table within CBMS for use by eligibility technicians to update the official copy of the client records. Overall the project is estimated to cost \$409,900 and can be completed in the first year of HRSA funding.

Interface with Dept of Revenue	Year 1	Year 2	Year 3	Year 4	Year 5
Division of Motor Vehicles (DMV)	\$100,000	\$100,000	\$20,000	\$20,000	\$20,000
CBMS Costs (\$105/hour)					
Requirements (240 Hours)	\$0	\$25,200	\$0	\$0	\$0
Design (480 Hours)	\$0	\$50,400	\$0	\$0	\$0
Application Changes (1,000 Hours)	\$0	\$105,000	\$0	\$0	\$0
Decision Table Changes (720 Hours)	\$0	\$75,600	\$0	\$0	\$0
Acceptance Test (860 Hours)	\$0	\$90,300	\$0	\$0	\$0
Implementation (80 Hours)	\$0	\$8,400	\$0	\$0	\$0
Total CBMS Costs	\$0	\$354,900	\$0	\$0	\$0
Total Project Costs	\$100,000	\$454,900	\$20,000	\$20,000	\$20,000

Budget Justification for Interface with Department of Revenue: CBMS estimated changes are higher than for Vital Statistics because there is not a current database that allows for query

interface. The CBMS changes include importing client data from the DMV interface into a temporary table within CBMS that will be used by eligibility technicians to update the official copy of the client records. The DMV will need to purchase additional servers and required software to complete this project.

Interface with Social Security	Year 1	Year 2	Year 3	Year 4	Year 5
CBMS Costs (\$105/hour)					
Requirements (240 Hours)	\$25,200	\$0	\$0	\$0	\$0
Design (640 Hours)	\$67,200	\$0	\$0	\$0	\$0
Application Changes (1,000 Hours)	\$105,000	\$0	\$0	\$0	\$0
Decision Table Changes (1,440 Hours)	\$151,200	\$0	\$0	\$0	\$0
Acceptance Test (1,220 Hours)	\$128,100	\$0	\$0	\$0	\$0
Implementation (80 Hours)	\$8,400	\$0	\$0	\$0	\$0
Total CBMS Costs	\$485,100	\$0	\$0	\$0	\$0
Total Project Costs	\$485,100	\$0	\$0	\$0	\$0

Budget Justification for Interface with Social Security: Effective January 1, 2010, States will be able to meet citizenship verification requirements by asking the Social Security Administration to verify names and Social Security numbers. Since the Department has yet to receive guidance on what system changes will be necessary, if any, from the Federal government to create the real-time system verification system with the Social Security Administration, the Department is only requesting funding to make appropriate modifications in CBMS. The CBMS estimates allow for the documentation of how the client's identify was verified and include design changes to the Department's current interface with the Social Security Administration.

Income and Eligibility Verification System (IEVS) Interface for Expansion Populations

- The Department requires that adult applicants submit copies of pay stubs or other paperwork to document their income. For the disabled and adult expansion populations, requiring paper documents would create barriers to enrollment for many applicants, and predictably complicate enrollment and renewal procedures for eligibility workers.
- In 2000, the Kaiser Commission on Medicaid and the Uninsured found that 70% of families surveyed believed that gathering materials for income verification was a barrier to Medicaid enrollment for their children.
- 2003 Urban Institute study of five states found that between 3% and 16% of renewals in a month were denied due to missing or incomplete verification of income or other data.
- Senate Bill 08-161 authorized Department to implement administration verification of income through existing wage databases, but the project has insufficient funding to implement.

IEVS – Income Verification Interface	Year 1	Year 2	Year 3	Year 4	Year 5
CBMS Costs (\$105/hour)					
Requirements (480 Hours)	\$50,400	\$0	\$0	\$0	\$0
Design (640 Hours)	\$67,200	\$0	\$0	\$0	\$0
Application Changes (480 Hours)	\$50,400	\$0	\$0	\$0	\$0
Decision Table Changes (1,920 Hours)	\$201,600	\$0	\$0	\$0	\$0
Acceptance Test (1,200 Hours)	\$126,000	\$0	\$0	\$0	\$0

Implementation (80 Hours)	\$8,400	\$0	\$0	\$0	\$0
Total CBMS Costs	\$504,000	\$0	\$0	\$0	\$0
Total Project Costs	\$504,000	\$0	\$0	\$0	\$0

Budget Justification for IEVS – Income Verification Interface: Income information from Department of Labor and Employment and the Income Eligibility Verification System (IEVS) databases is available to eligibility technicians, but without changes to CBMS, the information cannot be entered as an acceptable source of income verification. The CBMS costs include the creation of a new income type to handle these income verifications, decision table changes to determine eligibility using client statements, and at least eight weeks of development time.

Express Lane Eligibility/Automated Enrollment of Expansion Populations

- Under CHIPRA, states are encouraged to implement Express Lane Eligibility or automated enrollment allows for a streamlined process that helps minimize the administrative burdens of the enrollment and renewal process for applicants, while also improving efficiency and providing greater accountability.
- States that have implemented Express Lane Eligibility report that it is an effective means to
 increase enrollment while lowering ongoing operating costs and reducing erroneous
 eligibility determinations.
- House Bill 06-1270 establishes a demonstration project for three large school-based medical assistance sites to increase enrollment of eligible children to use information on the free and reduced-cost lunch program application to schedule interviews with families to determine if they are eligible for Medicaid or CHP+.

Coordination with Other Programs	Year 1	Year 2	Year 3	Year 4	Year 5		
Free and Reduced Lunch and Income Tax Records							
CBMS Costs (\$105/hour)							
Requirements (240 Hours)	\$25,200	\$25,200	\$0	\$0	\$0		
Design (480 Hours)	\$50,400	\$50,400	\$0	\$0	\$0		
Application Changes (320 Hours)	\$33,600	\$33,600	\$0	\$0	\$0		
Decision Table Changes (960 Hours)	\$100,800	\$100,800	\$0	\$0	\$0		
Acceptance Test (640 Hours)	\$67,200	\$67,200	\$0	\$0	\$0		
Implementation (80 Hours)	\$8,400	\$8,400	\$0	\$0	\$0		
Total CBMS Costs	\$285,600	\$285,600	\$0	\$0	\$0		
Total Project Costs	\$285,600	\$285,600	\$0	\$0	\$0		

Budget Justification for Free and Reduced Lunch and Income Tax Records: The CBMS changes would include the creation of a new CBMS window to capture whether a client is on the free or reduced-cost lunch program; decision table changes to determine eligibility based on similar mandatory programs that automatically grant a client eligibility without checking for other income or family size information; and eight weeks for development time. Overall the first phase of the project is estimated to cost \$285,600 and can be completed in the first year of HRSA funding. After completing the CBMS changes to implement the Express Lane Eligibility option for the free or reduced-cost lunch programs, the Department proposes similar changes to allow eligibility for Medicaid, CHP+, and the expansion populations to be determined through

state income tax information. This second phase of the project is estimated to cost \$285,600 and can be completed in the second year of HRSA funding.

Passive Re-Enrollment for Expansion Populations

Passive Re-Enrollment	Year 1	Year 2	Year 3	Year 4	Year 5		
Redeterminations with Pre-Populated Client Information							
CBMS Costs (\$105/hour)							
Requirements (400 Hours)	\$0	\$42,000	\$0	\$0	\$0		
Design (480 Hours)	\$0	\$50,400	\$0	\$0	\$0		
Application Changes (400 Hours)	\$0	\$42,000	\$0	\$0	\$0		
Decision Table Changes (1,920 Hours)	\$0	\$201,600	\$0	\$0	\$0		
Acceptance Test (1,160 Hours)	\$0	\$121,800	\$0	\$0	\$0		
Implementation (80 Hours)	\$0	\$8,400	\$0	\$0	\$0		
Total CBMS Costs		\$466,200					
Total Project Costs	\$0	\$466,200	\$0	\$0	\$0		

Budget Justification Redeterminations with Pre-Populated Client Information: The Department proposes to utilize a renewal form with pre-printed eligibility information that is sent to the parent/caretaker relative of the child with notice that the child's eligibility will be automatically renewed unless other information is provided to the State that affects the child's continued eligibility for the coverage expansions for children and parents. Once the process is developed, the Department would then use this pre-printed eligibility renewal form for the disabled and adult expansion populations. Due to the significant amount of changes to CBMS proposed in this grant application, we are not requesting HRSA funds for this project until the second year. The CBMS changes totaling \$466,200 include modifications to determine whether changes have occurred since the original application was submitted; modifications to the renewal form; updates to decision tables to determine eligibility using limited renewal information; and at least eight weeks for development.

Web Based Applications for Expansion Populations

- Work is underway by our CBMS vendor, Deloitte, to develop and implement a web-based online application for the current Medicaid and CHP+ clients that should be completed in early 2010.
- A growing number of low-income residents have access to computers and the Internet.
- Many states have experienced great success in developing online tools. In Massachusetts, approximately 50% of all applications are submitted online and the average time required to complete a Medicaid application dropped by 55% from 20 minutes to 9 minutes.

Web Based Applications	Year 1	Year 2	Year 3	Year 4	Year 5
Disabled Expansion Population	\$450,000	\$450,000	\$250,000	\$250,000	\$250,000
Adult Expansion Population	\$450,000	\$450,000	\$250,000	\$250,000	\$250,000
CICP Population	\$1,050,000	\$1,050,00	\$350,000	\$350,000	\$350,000
Total Project Cost	\$1,950,000	\$1,950,00	\$850,000	\$850,000	\$850,000

Budget Justification for Web Based Applications: The Department proposes to utilize HRSA funding to enhance the web-based application to cover the disabled and adult expansion populations. This would allow these new clients the opportunity apply for health care coverage over the Internet rather than submitting paper applications as originally envisioned. The Department assumes that its current contractor, Deloitte, could modify the existing Web Portal to handle the data entry requirement for the disabled and adult web-based applications using one-half the time required to implement the initial version of the Web Portal. The total estimated cost is \$900,000, with \$250,000 in annual costs for maintaining the web portal and web-based application. Due to significant development time and the need to implement other CBMS changes in the first year of HRSA funding, the Department requests that the funding for the design and programming be spread over the first two years of the grant. This would allow the web-based application to be functioning when the expansion programs are implemented in 2011.

Since eligibility for the Colorado Indigent Care Program (CICP) population is not contained in CBMS, the Department assumes that Deloitte would need to construct a new Web Portal at \$1,800,000, plus build an interface and database that would contain the CICP client eligibility information for an additional \$300,000. In addition, there will be an estimated \$350,000 in annual costs for maintaining the web portal and web-based application for this population.

3. Childless Adults and Buy-in for Individuals with Disabilities Implementation: The Department requests funding to develop potential program designs, including models for premium structures, cost-sharing provisions for expansion populations, including stakeholder feedback. Part of the implementation will also include focused provider recruitment to increase participation by providers that serve adults and individuals with complex medical needs.

Childless Adults and Disabled Buy-in Implementation	Year 1	Year 2	Year 3	Year 4	Year 5
Design of Benefit Package					
Adult Benefit Package Design Consultant	\$197,600	\$197,600	\$0	\$0	\$0
Stakeholder Meetings	\$49,200	\$49,200	\$49,200	\$49,200	\$12,300
Design of Benefit Package Cost	\$246,800	\$246,800	\$49,200	\$49,200	\$12,300
Expand Provider Participation					
Provider Database	\$75,000	\$75,000	\$75,000	\$75,000	\$75,000
Provider Recruiter	\$125,000	\$125,000	\$125,000	\$125,000	\$125,000
Provider Outreach	\$50,000	\$50,000	\$50,000	\$50,000	\$50,000
Expand Provider Participation Cost	\$250,000	\$250,000	\$250,000	\$250,000	\$250,000
Total Project Cost	\$496,800	\$496,800	\$299,200	\$299,200	\$262,300

Budget Justification for Childless Adults and Buy-in for Individuals with Disabilities Implementation: House Bill 09-1293 creates two new eligibility categories for Colorado Medicaid, the disabled buy-in program and childless adult benefit. Both require significant and specific benefit design work.

Adult Benefit Package Design Consultant: The Department will contract with a consultant(s) to assist with rigorous research of best practice models in other states and recommendations for Colorado. The buy-in program will entail determining appropriate cost-sharing, co-payments, premiums, and income and asset parameters. The childless adult benefit will require the determination of the amount, scope, and duration of services to be covered. Year 1 will be dedicated to researching superior models, determining feasibility for Colorado, and outlining program and benefit structure. Year 2 will be dedicated to finalizing program and benefit design. The following represent the assumptions regarding consultant costs:

Consultant Type	Total Hours by Consultant	Rate/Hour	Total Cost
Senior	320	\$175	\$56,000
Mid-Level	480	\$165	\$79,200
Junior	480	\$130	\$62,400
Total	1,280		\$197,600

Stakeholder Meetings: Engaging stakeholders who can assist with outreach to eligible but not enrolled populations and assist with effective and efficient enrollment is a priority. To identify community needs, key issues and best practices related to serving new populations, the Department will contract with a consultant(s) to conduct basic background research and provide facilitation support for regular stakeholder meetings. The Department estimates the need for at least one stakeholder meeting per month. These meetings would include hiring facilitators, travel arrangements for staff, room reservations, and general administrative duties. The Department estimates an average cost of \$4,100 per meeting. For 12 meetings each year in Year 1 through Year 4 of the HRSA grant, the cost is \$49,200 per year. In year 5 of the HRSA grant the Department expects that only three stakeholders meetings (\$12,300) would be necessary since the programs will be fully implemented.

Expand Provider Participation: The purpose of these activities is to promote provider participation in Medicaid/CHP+ through focused outreach and elimination of administrative barriers necessary to provide access to services after expansion population clients are enrolled. The Department requests funding (\$75,000/year) to access Peregrine database to regularly survey all Colorado providers on their participation in public insurance programs and panel status. The Department proposes to hire a provider recruiter with a health care background to recruit primary care and specialty providers for adults. Activities include site visits, presentations at professional meetings, development and analysis of surveys pertaining to provider participation, and collaboration with Department staff to pinpoint and resolve administrative barriers. The outreach consultant (\$50,000/year) will develop and disseminate outreach materials to assist with provider engagement, enrollment, and training. Activities include provider focus groups and drafting and production of fact sheets and training materials.

4. Premium Assistance Program: The Department requests SHAP funds to expand the CHP+ at Work program statewide, and increased capacity to support population newly eligible for CHP+.

CHP+ at Work Premium Assistance	Year 1	Year 2	Year 3	Year 4	Year 5
CHP+ at Work Contractor	\$0	\$900,000	\$900,000	\$900,000	\$900,000

MMIS Costs	\$368,757	\$0	\$0	\$0	\$0
CBMS Changes	\$447,300	\$0	\$0	\$0	\$0
Total Project Cost	\$816,057	\$900,000	\$900,000	\$900,000	\$900,000

<u>Budget Justification for CHP+ at Work Premium Assistance</u>: Existing resources within the Department have gathered the requirements for the change requests for CBMS and MMIS. Existing resources within the Department would be used to prepare a Request for Proposal (RFP) for a vendor to perform the marketing and recruitment activities. The premium assistance expansion statewide will be unsuccessful unless there is active engagement with employers and families.

5. Health Access Pueblo Community-Share Expansion: The Department is requesting funding to design, develop and implement a marketing and outreach plan to new businesses on the availability of Pueblo County's Health Access Program (HAP).

HAP Marketing and Outreach Plan	Year 1	Year 2	Year 3	Year 4	Year 5
Sales Executive	\$45,000	\$45,000	\$45,000	\$45,000	\$45,000
Equipment (Telephone, server, computers, including software, fax/copier scanner)	\$13,000	\$0	\$0	\$0	\$0
Installation and Technology Support	\$3,000	\$0	\$0	\$0	\$0
Public Relations and Advertising Campaign	\$35,000	\$20,000	\$20,000	\$20,000	\$20,000
Total Project Cost	\$96,000	\$65,000	\$65,000	\$65,000	\$65,000

Budget Justification for Health Access Pueblo Community-Share Expansion: Since August 2008, only 40 people have insurance through HAP. If the program is to be successful, resources must be devoted to hiring a sales executive and mounting an aggressive public relations and advertising campaign. The need for the program is clearly demonstrated and with focused efforts to reach employers and business, it is estimated that program participation can be increased to 1,000 by 2012. The costs are self-explanatory.

6. San Luis Valley Three-Share Community Start-Up: The Department is requesting SHAP funds to replicate Pueblo's HAP and create health care coverage for the working uninsured for San Luis Valley (SLV) Health Access Program. The SHAP funds will initially support the "community share."

SLV Health Access Program	Year 1	Year 2	Year 3	Year 4	Year 5
Health care cost reserves and shares of multi-share program	\$65,000	\$85,000	\$85,000	\$85,000	\$85,000
Total Project Cost	\$65,000	\$85,000	\$85,000	\$85,000	\$85,000

Budget Justification San Luis Valley Three-Share Community Start-Up: The objective for the SLV Health Access Program is to create access to services using currently untapped private dollars supplemented with grant funds during the early years to cover the third leg (the community portion) of the program's financing. The funding requested would provide that third share and possibly some reserve funds to protect program assets from extraordinary claims or

utilization in the early implementation period. The program has a plan in place to move towards sustainability without the need for grants or other sources of governmental funding, but this funding is critical to the initial phase, enabling the program to meet its purpose of providing high-quality health care coverage to qualified working uninsured residents of the San Luis Valley.

7. Weld County Evidence-Based Benefit Design Pilot: The Department is requesting SHAP funds to create an innovative benefit design tool that can be implemented easily and administered efficiently for carriers developing new insurance products targeted at previously uninsured populations.

Evidence-Based Benefit Design Pilot	Year 1	Year 2	Year 3	Year 4	Year 5
Personnel Costs, Travel, Supplies, Contractual, CHAT Tool and Research Meetings	\$559,200	\$335,025	\$289,300	\$289,300	\$314,500
Total Project Cost	\$559,200	\$335,025	\$289,300	\$289,300	\$314,500

Budget Justification for Evidence-Based Benefit Design Pilot: Year 1 start-up costs include \$339,000 for Personnel (Project Director, Project Manager, Benefit Design tool Development Director, Research Assistant); \$32,100 for Indirect - rent, utilities, telephone, computer, administrative assistance, meetings; \$20,800 for Travel (reimbursement for committee member travel costs, director and research assistant research travel, staff travel to public meetings); \$11,000 for Supplies (copies and meeting supplies, print publications); and \$135,000 for Contractual (DOI, HCPF, Independent Evaluator, Actuarial consulting, implementation consulting, practice guidelines and educational material consulting; and \$20,000 for CHAT tool. Year 2 costs include \$110,225 for Personnel; \$6,300 for indirect costs; \$5,500 for Travel; \$6,000 for Supplies, \$177,000 for Contractual; and \$30,000 for Benefit Design Tool Maintenance.

8. Evaluation

Evaluation	Year 1	Year 2	Year 3	Year 4	Year 5
General Evaluation Reporting	\$750,00	\$500,00	\$500,00	\$500,00	\$1,150,00
County Workload Changes	\$0	\$0	\$0	\$0	\$500,500
Expansion of Health Outcomes Survey	\$141,964	\$141,964	\$141,964	\$141,964	\$141,964
Independent Evaluation of Three-Way Share Model	\$30,000	\$30,000	\$30,000	\$30,000	\$30,000
Total Project Cost	\$921,964	\$671,964	\$671,964	\$671,964	\$1,821,964

Budget Justification for Evaluation: Based on industry standards and practices, evaluation is typically 10-15 percent of overall project costs. The overall evaluation costs are approximately 8% of the overall project costs. The Department has an impressive number of subject matter experts in our Business Analysis Section and in our Quality Improvement Section that have extensive experience with state data systems and evaluation methodology. Staff will be able to augment and support the work of an outside evaluation contractor.

Budget Justification for Health Outcomes Survey: One of the expansion populations under HB 09-1293 is the buy-in for individuals with disabilities with family income up to 450% FPL. The

Department proposes to use SHAP funding to hire a contractor to conduct a client satisfaction survey for this group of clients to measure whether the ability to participate in the buy-in program lead to improved life satisfaction due to the ability to earn more money while working while maintaining Medicaid coverage.

Budget Justification for County Administration Workload Study (Year 5): To establish the appropriate level of funding for County Administration costs, the Department will use baseline data from a 2007 county administration workload study conducted by Deloitte Development LLC for the Colorado Department of Human Services and the Department of Health Care Policy and Financing. This county administration workload study assessed the adequacy of staffing, workload standards, and time required to complete activities related to programs managed by the Department. This was accomplished through an analysis of county processes, including client applications, interviews, research and document validation, determination of eligibility for benefits, and case management reviews. The Department proposes to conduct a second county administration workload study during year 5 of the HRSA grant to measure project outcomes. The estimated cost of this workload study is \$500,000 based on the cost to complete the 2007 study.

9. Grant Management, Implementation, and Administrative Support

The Department has requested funding for additional FTE needed to complete specific phases of the HRSA grant project. These FTE are described in Attachment 4 "Job Descriptions for Key Personnel." The following table shows the number of FTE needed per year by HRSA project category.

HRSA FTE	Year 1	Year 2	Year 3	Year 4	Year 5
Eligibility Modernization: Streamlining the Application Process	\$612,407	\$569,803	\$596,103	\$445,515	\$466,227
Personnel Costs	\$417,480	\$438,354	\$460,271	\$345,204	\$362,464
Fringe Benefits	\$83,496	\$87,671	\$92,054	\$69,041	\$72,493
Indirect Costs	\$111,431	\$43,778	\$43,778	\$31,270	\$31,270
FTE Count	7.0	7.0	7.0	5.0	5.0
Maximizing Outreach, Retention and Enrollment	\$607,528	\$572,141	\$595,872	\$620,790	\$646,952
Personnel Costs	\$376,680	\$395,514	\$415,290	\$436,055	\$457,857
Fringe Benefits	\$75,336	\$79,103	\$83,058	\$87,211	\$91,571
Indirect Costs	\$155,512	\$97,524	\$97,524	\$97,524	\$97,524
FTE Count	6.0	6.0	6.0	6.0	6.0
Premium Assistance Program	\$273,764	\$256,070	\$267,936	\$191,292	\$200,231
Personnel Costs	\$188,340	\$197,757	\$207,645	\$148,987	\$156,436
Fringe Benefits	\$37,668	\$39,551	\$41,529	\$29,797	\$31,287
Indirect Costs	\$47,756	\$18,762	\$18,762	\$12,508	\$12,508
FTE Count	3.0	3.0	3.0	2.0	2.0
Evaluation	\$85,820	\$79,303	\$82,950	\$86,778	\$90,798

Personnel Costs	\$57,876	\$60,770	\$63,809	\$66,999	\$70,349
Fringe Benefits	\$11,575	\$12,154	\$12,762	\$13,400	\$14,070
Indirect Costs	\$16,369	\$6,379	\$6,379	\$6,379	\$6,379
FTE Count	1.0	1.0	1.0	1.0	1.0
Grant Management	\$610,046	\$498,094	\$435,964	\$456,201	\$477,448
Personnel Costs	\$415,512	\$383,808	\$337,245	\$354,109	\$371,815
Fringe Benefits	\$83,103	\$76,762	\$67,449	\$70,822	\$74,363
Indirect Costs	\$111,431	\$37,524	\$31,270	\$31,270	\$31,270
FTE Count	7.0	6.0	5.0	5.0	5.0
Administrative Support	\$200,425	\$179,064	\$187,079	\$195,494	\$204,331
Personnel Costs	\$127,224	\$133,585	\$140,264	\$147,277	\$154,641
Fringe Benefits	\$25,445	\$26,717	\$28,053	\$29,455	\$30,928
Indirect Costs	\$47,756	\$18,762	\$18,762	\$18,762	\$18,762
FTE Count	3.0	3.0	3.0	3.0	3.0
Administrative Travel for SHAP	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000
Total Project Cost	\$2,390,991	\$2,155,475	\$2,166,904	\$1,997,070	\$2,086,987

In addition, the Department has existing base resources for FTE to be hired for projects under House Bill (HB) 09-1293 beginning in Year 1 of the proposed HRSA project. The funding for these FTE is organized by a subset of the same project categories included in the HRSA grant application. The table below shows the estimated ratio for these FTE by three project categories.

HB 09-1293 FTE	Year 1	Year 2	Year 3	Year 4	Year 5
Eligibility Modernization: Streamlining the Application Process	\$508,896	\$851,280	\$1,119,062	\$1,119,062	\$1,119,062
Estimated Ratio of FTE for Project	25%	25%	25%	25%	25%
Population Expansions	\$1,465,621	\$2,451,685	\$3,222,899	\$3,222,899	\$3,222,899
Estimated Ratio of FTE for Project	72%	72%	72%	72%	72%
Administrative Support	\$61,068	\$102,154	\$134,287	\$134,287	\$134,287
Estimated Ratio of FTE for Project	3%	3%	3%	3%	3%
Total Project Cost	\$2,310,046	\$2,075,172	\$2,082,954	\$1,909,292	\$1,995,190

Project Description	Total Funds	State Funds	Federal Medicaid	HRSA
Total	\$20,971,202	\$5,064,004	\$5,940,587	\$9,966,612
Maximizing Outreach, Retention and Enrollment	\$2,959,150	\$732,811	\$732,811	\$1,493,528
Client Outreach	\$886,000	\$0	\$0	\$886,000
Personnel	\$2,073,150	\$732,811	\$732,811	\$607,528
Eligibility Modernization: Streamlining Application Process	\$13,383,350	\$3,930,083	\$5,106,260	\$4,347,007
Automation of Vital Statistics Retrieval	\$409,900	\$0	\$0	\$409,900
Interface with Department of Revenue	\$100,000	\$0	\$0	\$100,000
Interface with Social Security	\$485,100	\$0	\$0	\$485,100
IEVS – Income Verification Interface	\$504,000	\$0	\$0	\$504,000
Coordination with Other Programs - Free and Reduced Lunch	\$285,600	\$0	\$0	\$285,600
Coordination with Other Programs - Income Tax Records	\$0	\$0	\$0	\$0
Eligibility Modernization Vendor Redeterminations	\$3,920,590	\$1,372,207	\$2,548,384	\$0
Redeterminations with Pre-Populated Client Information	\$0	\$0	\$0	\$0
Web Based Applications	\$6,556,857	\$2,303,429	\$2,303,429	\$1,950,000
Personnel	\$1,121,303	\$254,448	\$254,448	\$612,407
Childless Adults and Disabled Buy-in Implementation	\$496,800	\$0	\$0	\$496,800
Design of Benefit Package	\$246,800	\$0	\$0	\$246,800
Expand Provider Participation	\$250,000	\$0	\$0	\$250,000
Premium Assistance Program	\$1,089,821	\$0	\$0	\$1,089,821
CHP+ at Work Premium Assistance	\$816,057	\$0	\$0	\$816,057
Personnel	\$273,764	\$0	\$0	\$273,764
Community Multi-Share Expansions	\$460,594	\$299,594	\$0	\$161,000
Health Access Pueblo Community-Share Expansion	\$96,000	\$0	\$0	\$96,000
San Luis Valley Three-Share Community Start-up	\$364,594	\$299,594	\$0	\$65,000
Weld County Evidence-Based Benefit Design Pilot	\$559,200	\$0	\$0	\$559,200
Evaluation	\$1,149,748	\$70,982	\$70,982	\$1,007,784
Evaluation Reporting	\$1,063,928	\$70,982	\$70,982	\$921,964
Personnel	\$85,820	\$0	\$0	\$85,820
Grant Management	\$611,046	\$0	\$0	\$611,046
Administrative Travel	\$1,000	\$0	\$0	\$1,000
Personnel	\$610,046	\$0	\$0	\$610,046
Administrative Support	\$261,493	\$30,534	\$30,534	\$200,425

Project Description	Total Funds	State Funds	Federal Medicaid	<u>HRSA</u>
Total	\$20,340,433	\$4,724,582	\$5,823,888	\$9,791,964
Maximizing Outreach, Retention and Enrollment	\$4,929,826	\$1,225,842	\$1,225,842	\$2,478,141
Client Outreach	\$1,906,000	\$0	\$0	\$1,906,000
Personnel	\$3,023,826	\$1,225,842	\$1,225,842	\$572,141
Eligibility Modernization: Streamlining Application Process	\$11,194,299	\$3,021,809	\$4,425,987	\$3,746,503
Automation of Vital Statistics Retrieval	\$20,000	\$0	\$0	\$20,000
Interface with Department of Revenue	\$454,900	\$0	\$0	\$454,900
Interface with Social Security	\$0	\$0	\$0	\$0
IEVS – Income Verification Interface	\$0	\$0	\$0	\$0
Coordination with Other Programs - Free and Reduced Lunch	\$0	\$0	\$0	\$0
Coordination with Other Programs - Income Tax Records	\$285,600	\$0	\$0	\$285,600
Eligibility Modernization Vendor Redeterminations	\$4,680,591	\$1,638,207	\$3,042,384	\$0
Redeterminations with Pre-Populated Client Information	\$466,200	\$0	\$0	\$466,200
Web Based Applications	\$3,865,926	\$957,963	\$957,963	\$1,950,000
Personnel	\$1,421,082	\$425,640	\$425,640	\$569,803
Childless Adults and Disabled Buy-in Implementation	\$596,800	\$50,000	\$50,000	\$496,800
Design of Benefit Package	\$346,800	\$50,000	\$50,000	\$246,800
Expand Provider Participation	\$250,000	\$0	\$0	\$250,000
Premium Assistance Program	\$1,156,070	\$0	\$0	\$1,156,070
CHP+ at Work Premium Assistance	\$900,000	\$0 \$0	\$0 \$0	\$900,000
Personnel	\$256,070	\$0 \$0	\$0 \$0	\$256,070
		·	\$0	
Community Multi-Share Expansions	\$449,871 \$65,000	\$299,871 \$0	\$0 \$0	\$150,000 \$65,000
Health Access Pueblo Community-Share Expansion San Luis Valley Three-Share Community Start-up	\$65,000 \$384,871	\$299,871	\$0 \$0	\$65,000 \$85,000
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Weld County Evidence-Based Benefit Design Pilot	\$340,025	\$5,000	\$0	\$335,025
Evaluation	\$893,231	\$70,982	\$70,982	\$751,267
Evaluation Reporting	\$813,928	\$70,982	\$70,982	\$671,964
Personnel	\$79,303	\$0	\$0	\$79,303
Grant Management	\$499,094	\$0	\$0	\$499,094
Administrative Travel	\$1,000	\$0	\$0	\$1,000
Personnel	\$498,094	\$0	\$0	\$498,094
Administrative Support	\$281,218	\$51,077	\$51,077	\$179,064

Project Description	Total Funds	State Funds	Federal Medicaid	<u>HRSA</u>
Total Maximizing Outreach, Retention and Enrollment Client Outreach Personnel	\$19,787,153	\$5,612,465	\$6,816,321	\$7,358,368
	\$5,809,771	\$1,611,449	\$1,611,449	\$2,586,872
	\$1,991,000	\$0	\$0	\$1,991,000
	\$3,818,771	\$1,611,449	\$1,611,449	\$595,872
Eligibility Modernization: Streamlining Application Process Automation of Vital Statistics Retrieval Interface with Department of Revenue Interface with Social Security IEVS – Income Verification Interface Coordination with Other Programs - Free and Reduced Lunch Coordination with Other Programs - Income Tax Records Eligibility Modernization Vendor Redeterminations Redeterminations with Pre-Populated Client Information Web Based Applications Personnel	\$9,900,275 \$20,000 \$20,000 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$1,715,165	\$3,472,426 \$0 \$0 \$0 \$0 \$0 \$0 \$2,336,376 \$0 \$576,519 \$559,531	\$4,941,746 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$3,805,696 \$0 \$576,519 \$559,531	\$1,486,103 \$20,000 \$20,000 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0
Childless Adults and Disabled Buy-in Implementation Design of Benefit Package Expand Provider Participation	\$549,200	\$125,000	\$125,000	\$299,200
	\$299,200	\$125,000	\$125,000	\$49,200
	\$250,000	\$0	\$0	\$250,000
Premium Assistance Program CHP+ at Work Premium Assistance Personnel	\$1,167,936	\$0	\$0	\$1,167,936
	\$900,000	\$0	\$0	\$900,000
	\$267,936	\$0	\$0	\$267,936
Community Multi-Share Expansions Health Access Pueblo Community-Share Expansion San Luis Valley Three-Share Community Start-up	\$415,464	\$265,464	\$0	\$150,000
	\$65,000	\$0	\$0	\$65,000
	\$350,464	\$265,464	\$0	\$85,000
Weld County Evidence-Based Benefit Design Pilot	\$289,300	\$0	\$0	\$289,300
Evaluation Evaluation Reporting Personnel	\$896,878	\$70,982	\$70,982	\$754,914
	\$813,928	\$70,982	\$70,982	\$671,964
	\$82,950	\$0	\$0	\$82,950
Grant Management Administrative Travel Personnel	\$436,964	\$0	\$0	\$436,964
	\$1,000	\$0	\$0	\$1,000
	\$435,964	\$0	\$0	\$435,964
Administrative Support	\$321,366	\$67,144	\$67,144	\$187,079

Project Description	Total Funds	State Funds	Federal Medicaid	<u>HRSA</u>
Total Maximizing Outreach, Retention and Enrollment Client Outreach Personnel	\$21,901,984 \$6,024,689 \$2,181,000 \$3,843,689	\$6,610,779 \$1,611,449 \$0 \$1,611,449	\$7,912,671 \$1,611,449 \$0 \$1,611,449	\$7,378,534 \$2,801,790 \$2,181,000 \$620,790
Eligibility Modernization: Streamlining Application Process Automation of Vital Statistics Retrieval Interface with Department of Revenue Interface with Social Security IEVS – Income Verification Interface Coordination with Other Programs - Free and Reduced Lunch Coordination with Other Programs - Income Tax Records Eligibility Modernization Vendor Redeterminations Redeterminations with Pre-Populated Client Information Web Based Applications Personnel	\$11,959,815 \$20,000 \$20,000 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$1,850,000 \$1,850,000 \$1,564,577	\$4,561,204 \$0 \$0 \$0 \$0 \$0 \$0 \$3,501,673 \$0 \$500,000 \$559,531	\$6,063,096 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$5,003,565 \$0 \$500,000 \$559,531	\$1,335,515 \$20,000 \$20,000 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$445,515
Childless Adults and Disabled Buy-in Implementation Design of Benefit Package Expand Provider Participation	\$499,200	\$100,000	\$100,000	\$299,200
	\$249,200	\$100,000	\$100,000	\$49,200
	\$250,000	\$0	\$0	\$250,000
Premium Assistance Program CHP+ at Work Premium Assistance Personnel	\$1,091,292	\$0	\$0	\$1,091,292
	\$900,000	\$0	\$0	\$900,000
	\$191,292	\$0	\$0	\$191,292
Community Multi-Share Expansions Health Access Pueblo Community-Share Expansion San Luis Valley Three-Share Community Start-up	\$350,000	\$200,000	\$0	\$150,000
	\$65,000	\$0	\$0	\$65,000
	\$285,000	\$200,000	\$0	\$85,000
Weld County Evidence-Based Benefit Design Pilot	\$289,300	\$0	\$0	\$289,300
Evaluation Evaluation Reporting Personnel	\$900,706	\$70,982	\$70,982	\$758,742
	\$813,928	\$70,982	\$70,982	\$671,964
	\$86,778	\$0	\$0	\$86,778
Grant Management Administrative Travel Personnel	\$457,201	\$0	\$0	\$457,201
	\$1,000	\$0	\$0	\$1,000
	\$456,201	\$0	\$0	\$456,201
Administrative Support	\$329,782	\$67,144	\$67,144	\$195,494

Project Description	Total Funds	State Funds	Federal Medicaid	HRSA
Total	\$24,966,652	\$7,692,640	\$8,996,461	\$8,277,551
Maximizing Outreach, Retention and Enrollment	\$5,721,651	\$1,611,449	\$1,611,449	\$2,498,752
Client Outreach	\$1,851,800	\$0	\$0	\$1,851,800
Personnel	\$3,869,851	\$1,611,449	\$1,611,449	\$646,952
Eligibility Modernization: Streamlining Application Process	\$14,141,178	\$5,638,065	\$7,146,886	\$1,356,227
Automation of Vital Statistics Retrieval	\$20,000	\$0	\$0	\$20,000
Interface with Department of Revenue	\$20,000	\$0	\$0	\$20,000
Interface with Social Security	\$0	\$0	\$0	\$0
IEVS – Income Verification Interface	\$0	\$0	\$0	\$0
Coordination with Other Programs - Free and Reduced Lunch	\$0	\$0	\$0	\$0
Coordination with Other Programs - Income Tax Records	\$0	\$0	\$0	\$0
Eligibility Modernization Vendor Redeterminations	\$10,665,889	\$4,578,534	\$6,087,355	\$0
Redeterminations with Pre-Populated Client Information	\$0	\$0	\$0	\$0
Web Based Applications	\$1,850,000	\$500,000	\$500,000	\$850,000
Personnel	\$1,585,289	\$559,531	\$559,531	\$466,227
Childless Adults and Disabled Buy-in Implementation	\$462,300	\$100,000	\$100,000	\$262,300
Design of Benefit Package	\$212,300	\$100,000	\$100,000	\$12,300
Expand Provider Participation	\$250,000	\$0	\$0	\$250,000
Premium Assistance Program	\$1,100,231	\$0	\$0	\$1,100,231
CHP+ at Work Premium Assistance	\$900,000	\$0	\$0	\$900,000
Personnel	\$200,231	\$0	\$0	\$200,231
Community Multi-Share Expansions	\$350,000	\$200,000	\$0	\$150,000
Health Access Pueblo Community-Share Expansion	\$65,000	\$0	\$0	\$65,000
San Luis Valley Three-Share Community Start-up	\$285,000	\$200,000	\$0	\$85,000
Weld County Evidence-Based Benefit Design Pilot	\$319,500	\$5,000	\$0	\$314,500
Evaluation	\$2,054,726	\$70,982	\$70,982	\$1,912,762
Evaluation Reporting	\$1,963,928	\$70,982	\$70,982	\$1,821,964
Personnel	\$90,798	\$0	\$0	\$90,798
Grant Management	\$478,448	\$0	\$0	\$478,448
Administrative Travel	\$1,000	\$0	\$0	\$1,000
Personnel	\$477,448	\$0	\$0	\$477,448
Administrative Support	\$338,619	\$67,144	\$67,144	\$204,331

Sustainability Funding

Project Description	Total Funds	State Funds	Federal Medicaid	<u>HRSA</u>
Total	\$20,009,059	\$9,349,153	\$10,659,906	\$0
Maximizing Outreach, Retention and Enrollment	\$4,803,979	\$2,401,989	\$2,401,989	\$0
Client Outreach	\$1,581,080	\$790,540	\$790,540	\$0
Personnel	\$3,222,899	\$1,611,449	\$1,611,449	\$0
Eligibility Modernization: Streamlining Application Process	\$13,753,493	\$6,118,870	\$7,634,623	\$0
Automation of Vital Statistics Retrieval	\$20,000	\$10,000	\$10,000	\$0
Interface with Department of Revenue	\$20,000	\$10,000	\$10,000	\$0
Interface with Social Security	\$0	\$0	\$0	\$0
IEVS – Income Verification Interface	\$0	\$0	\$0	\$0
Coordination with Other Programs - Free and Reduced Lunch	\$0	\$0	\$0	\$0
Coordination with Other Programs - Income Tax Records	\$0	\$0	\$0	\$0
Eligibility Modernization Vendor Redeterminations	\$10,744,431	\$4,614,339	\$6,130,092	\$0
Redeterminations with Pre-Populated Client Information	\$0	\$0	\$0	\$0
Web Based Applications	\$1,850,000	\$925,000	\$925,000	\$0
Personnel	\$1,119,062	\$559,531	\$559,531	\$0
Childless Adults and Disabled Buy-in Implementation	\$212,300	\$106,150	\$106,150	\$0
Design of Benefit Package	\$212,300	\$106,150	\$106,150	\$0
Expand Provider Participation	\$0	\$0	\$0	\$0
Premium Assistance Program	\$900,000	\$450,000	\$450,000	\$0
CHP+ at Work Premium Assistance	\$900,000	\$450,000	\$450,000	\$0 \$0
Personnel	\$0	\$0	\$0	\$0
Community Multi-Share Expansions	\$200,000	\$200,000	\$0	\$0
Health Access Pueblo Community-Share Expansion	\$0	\$0	\$0	\$0
San Luis Valley Three-Share Community Start-up	\$200,000	\$200,000	\$0	\$0
Weld County Evidence-Based Benefit Design Pilot	\$5,000	\$5,000	\$0	\$0
Evaluation	\$0	\$0	\$0	\$0
Evaluation Reporting	\$0	\$0	\$0	\$0
Personnel	\$0	\$0	\$0	\$0
Grant Management	\$0	\$0	\$0	\$0
Administrative Travel	\$0	\$0	\$0	\$0
Personnel	\$0	\$0	\$0	\$0
Administrative Support	\$134,287	\$67,144	\$67,144	\$0